AMA/Specialty Society RVS Update Committee

Five-Year Review Recommendations

October 2005

Volume 1

AMA/Specialty Society RVS Update Committee
Five-Year Review Recommendations
October 2005

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AMA/Specialty Society RVS Update Committee
Summary of All Codes in the Five-Year Review

CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
00797	4	Anesth, Surgery for Obesity	8.00	11 00	1	11.00	8,521
10060	HCPAC	Drainage of skin abscess	1.17	1.50	1	1 50	603,536
11040	HCPAC	Debride skin, partial	0.50	0 65	4	0.55	1,287,162
11041	HCPAC	Debride skin, full	0 82	0 80	3	0 80	738,321
11042	HCPAC	Debride skin/tissue	1 12	1.20	2	1.12	944,576
11100	1	Biopsy, skin lesion	0.81	1.00	2	0.81	1,981,129
11400	1	Exc tr-ext b9+marg 0 5<cm	0 85	1 13	2	0 85	58,652
11401	1	Exc tr-ext b9+marg 0.6-1cm	1.23	1.43	2	1.23	103,548
11402	1	Exc tr-ext b9+marg 1.1-2 cm	1 51	1.80	4	1.40	123,031
11403	1	Exc tr-ext b9+marg 2 1-3 cm	1.79	2.20	2	1.79	58,319
11404	1	Exc tr-ext b9+marg 3.1-4 cm	2 06	2.08	2	2 06	23,393
11406	1	Exc tr-ext b9+marg >4 0cm	2.76	3.80	4	3 20	23,256
11420	1	Exc h-f-nk-sp b9+marg 0.5<	0.98	1.50	2	0.98	37,395
11421	1	Exc h-f-nk-sp b9+marg 0.6-1	1 42	2 15	2	1 42	49,725
11422	1	Exc h-f-nk-sp b9+marg 1.1-2	1.63	2.25	2	1.63	51,753
11423	1	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.24	2	2.01	22,012
11424	1	Exc h-f-nk-sp b9+marg 3 1-4	2.43	2.61	2	2 43	7,718
11426	1	Exc h-f-nk-sp b9+marg >4.0 cm	3.77	3.78	2	3.77	5,430
11440	1	Exc face-mm b9+marg 0 5 < cm	1 06	1 65	4	1 00	71,485
11441	1	Exc face-mm b9+marg 0 6-1 cm	1.48	1 83	2	1.48	79,679
11442	1	Exc face-mm b9+marg 1 1-2 cm	1.72	2.00	2	1.72	61,434
11443	1	Exc face-mm b9+marg 2.1-3 cm	2.29	2 73	2	2 29	18,269
11444	1	Exc face-mm b9+marg 3.1-4 cm	3.14	3.30	2	3.14	5,200

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
11446	1	Exc face-mm b9+marg >4 cm	4.48	4.50	2	4 48	2,738
11450	1	Removal, sweat gland lesion	2 73		7		702
11451	1	Removal, sweat gland lesion	3 94		7		243
11462	1	Removal, sweat gland lesion	2.51		7		398
11463	1	Removal, sweat gland lesion	3 94		7		130
11470	1	Removal, sweat gland lesion	3.25		7		428
11471	1	Removal, sweat gland lesion	4.40		7		168
11600	1	Exc tr-ext mlg+marg 0.5<cm	1 31	1.60	2	1 31	9,023
11601	1	Exc tr-ext mlg+marg 0.6-1cm	1.80	2 10	4	1 75	39,378
11602	1	Exc tr-ext mlg+marg 1.1-2cm	1 95	2.50	2	1.95	121,520
11603	1	Exc tr-ext mlg+marg 2 1-3<cm	2.19	3 42	4	2 50	61,629
11604	1	Exc tr-ext mlg+marg 3.1-4cm	2.40	3 80	4	2.85	24,581
11606	1	Exc tr-ext mlg+marg >4cm	3.42	5 25	4	4 70	22,555
11620	1	Exc h-f-nk-sp mlg+marg 0.5<	1.19	1 78	4	1.32	4,813
11621	1	Exc h-f-nk-sp mlg+marg 0.6-1	1 76	2 13	2	1.76	21,521
,622	1	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.70	2	2.09	53,607
11623	1	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	3.06	4	2.79	23,235
11624	1	Exc h-f-nk-sp mlg+marg 3 1-4	3.06	3 48	4	3.30	8,418
11626	1	Exc h-f-nk-sp mlg+marg >4cm	4.29	4 90	2	4 29	7,033
11640	1	Exc face-mm malig+marg 0 5<	1.35	1.85	2	1.35	26,146
11641	1	Exc face-mm malig+marg 0 6-1	2.16	2 50	4	1.85	93,199
11642	1	Exc face-mm malig+marg 1.1-2	2.59	2.50	4	2 30	152,434
11643	1	Exc face-mm malig+marg 2 1-3	3.10	3.60	2	3.10	50,764
11644	1	Exc face-mm malig+marg 3 1-4	4.02	4 61	2	4.02	16,480
11646	1	Exc face-mm malig+marg>4	5.94	6.30	2	5.94	10,275
11730	HCPAC	Removal of nail plate	1.13	1.10	3	1.10	674,395

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
11960	1	Insert tissue expander (s)	9.07		7		280
12052	1	Layer closure of wound(s)	2.77	3 20	2	2 77	73,449
13121	1	Repair of wound or lesion	4.32	4 56	2	4.32	47,763
14040	1	Skin tissue rearrangement	7.86	8.55	2	7.86	75,938
14060	1	Skin tissue rearrangement	8 49	9.10	2	8 49	89,343
15100	1	Skin split graft	9.04	9.00	2	9.04	21,432
15240	1	Skin full graft	9 03	9 40	2	9.03	11,260
15732	1	Muscle-skin graft, head/neck	17.81	18.25	5		10,101
15734	1	Muscle-skin graft, trunk	17 76	18.33	2	17 76	12,638
15831	1	Excise excessive skin tissue	12.38		5		1,649
17003	1	Destroy lesions, 2-14	0.15	0.55	4	0 07	14,967,497
17262	1	Destruction of skin lesions	1.58	1 70	2	1 58	155,455
17281	1	Destruction of skin lesions	1.72	1 80	2	1.72	149,754
17304	1	1 stage mohs, up to 5 spec	7 59	9.50	5		350,100
17305	1	2 stage mohs, up to 5 spec	2 85	6.00	5		187,597
19180	7	Removal of breast	8.79	15.25	4	14.67	15,560
19361	1	Breast reconstruction	19.23	24.00	7		486
20600	2	Drain/inject, joint/bursa	0 66	0 94	2	0 66	363,057
20610	2	Drain/inject, joint/bursa	0.79	1.80	2	0.79	4,532,254
20680	2	Removal of support implant	3.34	6.50	4	5 86	50,794
20692	2	Apply bone fixation device	6.40	15 00	5		1,526
21145	1	Reconstruct midface, lefort	19.91	23 50	4	21.84	12
21146	1	Reconstruct midface, lefort	20 68	27.50	4	22.55	2
21147	1	Reconstruct midface, lefort	21 74	28.13	4	23.32	3
21365	1	Treat cheek bone fracture	14.93		7		495
21366	1	Treat cheek bone fracture	17.74		7		12

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
21395	1	Treat eye socket fracture	12.66	16 00	4	13 88	15
21432	1	Treat craniofacial fracture	8 60		7		9
21435	1	Treat craniofacial fracture	17.22		7		16
21436	1	Treat craniofacial fracture	28 00		7		2
21470	1	Treat lower jaw fracture	15 32	18.75	7		450
21556	2	Remove lesion neck/chest	5.56	15 50	5		5,923
21935	2	Remove tumor, back	17 93		7		1,333
22520	3	Percut vertebroplasty thor	8 90	8.90	2	8.90	13,992
22554	3	Neck spine fusion	18.59	16.40	3	16 40	24,477
22612	3	Lumbar spine fusion	20 97	22.58	4	22.00	43,306
22840	3	Insert spine fixation device	12.52	12.52	2	12.52	15,975
23076	2	Removal of shoulder lesion	7 62	15 00	5		2,053
23200	2	Removal of collar bone	12 06	24.00	5		31
23210	2	Removal of shoulder blade	12.47	28 00	5		42
23220	2	Partial removal of humerus	14 54	28 00	5		28
3515	2	Treat clavicle fracture	7.40		5		475
23585	2	Treat scapula fracture	8.95		5		281
23615	2	Treat humerus fracture	9 34		5		5,829
23616	2	Treat humerus fracture	21.24		5		3,447
23630	2	Treat humerus fracture	7 34		5		736
23670	2	Treat dislocation/fracture	7.89		5		170
23680	2	Treat dislocation/fracture	10 04		5		163
24076	2	Remove arm/elbow lesion	6.29	16.00	5		1,906
24077	2	Remove tumor of arm, elbow	11.74	22 00	5		779
24150	2	Extensive humerus surgery	13 25	30.00	5		60
24151	2	Extensive humerus surgery	15.56		7		3

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
24152	2	Extensive radius surgery	10.04	25 00	5		4
24153	2	Extensive radius surgery	11.52		7		
24363	2	Replace elbow joint	18 46	21.00	4	21.07	1,013
24430	2	Repair of humerus	12 79	15 50	4	14.00	641
24545	2	Treat humerus fracture	10 44		5		1,067
24546	2	Treat humerus fracture	15 67		5		1,007
24575	2	Treat humerus fracture	10.64		5		139
24579	2	Treat humerus fracture	11 58		5		520
24635	2	Treat elbow fracture	13 17		5		550
24665	2	Treat radius fracture	8.13		5		594
24685	2	Treat ulnar fracture	8 79		5		5,596
25076	2	Removal forearm lesion deep	4.91	15 00	5		1,693
25077	2	Remove tumor, forearm/wrist	9.75	22.00	5		575
25170	2	Extensive forearm surgery	11 07	26.00	5		16
25447	2	Repair wrist joint(s)	10 35	10 35	2	10.35	8,991
25515	2	Treat fracture of radius	9.17		5		567
25526	2	Treat fracture of radius	12 96		5		133
25545	2	Treat fracture of ulna	8 89		5		1,011
25574	2	Treat fracture radius & ulna	7.00		5		301
25575	2	Treat fracture radius/ulna	10 43		5		1,106
25620	2	Treat fracture radius ulna	8 54		5		12,450
25628	2	Treat wrist bone fracture	8 42		5		182
26055	2	Incise finger tendon sheath	2.69	3.99	2	2.69	59,370
26160	2	Remove tendon sheath lesion	3 15	4.05	2	3 15	12,971
26600	2	Treat metacarpal fracture	1 96	2.40	1	2.40	16,336
26615	2	Treat metacarpal fracture	5.32		5		1,341

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
26665	2	Treat thumb fracture	7 59		5		98
26685	2	Treat hand dislocation	6.97		5		73
26715	2	Treat knuckle dislocation	5 73		5		206
26735	2	Treat finger fracture, each	5.97		5		1,596
26746	2	Treat finger fracture, each	5 80		5		897
26765	2	Treat finger fracture, each	4.16		5		1,892
26785	2	Treat finger dislocation	4 20		5		520
26951	2	Amputation of finger/thumb	4.58	6 00	4	5 25	7,509
27048	2	Remove hip/pelvis lesion	6 24	18.00	5		1,032
27049	2	Remove tumor, hip/pelvis	13 64	28 00	5		510
27076	2	Extensive hip surgery	22.09	40 00	5		118
27078	2	Extensive hip surgery	13.42	35.00	5		59
27130	2	Total hip arthroplasty	20.09	20 09	2	20 09	106,878
27236	2	Treat thigh fracture	15.58	15.58	2	15.58	84,217
27248	2	Treat thigh fracture	10.43		5		1,433
328	2	Removal of thigh lesion	5.56	17.00	5		1,953
27329	2	Remove tumor, thigh/knee	14.12	25.00	5		1,099
27365	2	Extensive leg surgery	16.25	30.00	5		350
27447	2	Total knee arthroplasty	21.45	21 45	2	21 45	246,836
27465	2	Shortening of thigh bone	13.85	17.50	1	17.50	26
27470	2	Repair of thigh	16.05	16 05	2	16 05	612
27472	2	Repair/graft of thgh	17.69	19.82	5		560
27511	2	Treatment of thigh fracture	13.62		5		4,093
27513	2	Treatment of thigh fracture	17.89		5		2,477
27514	2	Treatment of thigh fracture	17.27		5		1,246
27519	2	Treat thigh fx growth plate	15.00		5		19

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CPT ode	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
27535	2	Treat knee fracture	11.48		5		2,549
27540	2	Treat knee fracture	13.08		5		107
27556	2	Treat knee dislocation	14.39		5		74
27603	7	Drain lower leg lesion	4 93		7		5,106
27615	2	Removel tumor, lower leg	12 54	23 00	5		983
27619	2	Remove lower leg lesion	8.39	16.00	5		1,034
27645	2	Extensive lower leg surgery	14.15	30.00	5		62
27646	2	Extensive lower leg surgery	12.64	25.00	5		32
27647	2	Extensive ankle/heel surgery	12.22	20 00	5	20 00	159
27709	2	Incision of tibia and fibula	9 94	19.00	4	16.50	161
27720	2	Repair of tibia	11 77	18 50	5		564
27766	2	Treatment of ankle fracture	8.35		5		1,557
27784	2	Treatment of fibula fracture	7 10		5		321
27792	2	Treatment of ankle fracture	7.65		5		5,172
?7814	2	Treatment of ankle fracture	10.66		5		11,719
822	2	Treatment of ankle fracture	10 98		5		6,097
27826	2	Treat lower leg fracture	8.53		5		176
27827	2	Treat lower leg fracture	14 04		5		658
27828	2	Treat lower leg fracture	16.21		5		913
27829	2	Treat lower leg joint	5 48		5		1,693
27832	2	Treat lower leg dislocation	6.48		5		8
27880	7	Amputation of lower leg	11 83	13.75	1	13.75	20,589
28045	2	Excision of foot lesion	4.71	14.00	5		3,061
28415	2	Treat heel fracture	15 95		5		775
28445	2	Treat ankle fracture	15.60		5		265
28465	2	Treat mid foot fracture, each	7.00		5		275

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
28485	2	Treat metatarsal fracture	5 70		5		1,858
28505	2	Treat big toe fracture	3.80		5		421
28525	2	Treat toe fracture	3.32		5		319
28555	2	Repair foot dislocation	6 29		5		138
28585	2	Repair foot dislocation	7 98		5		167
28615	2	Repair foot dislocation	7.76		5		677
28645	2	Repair toe dislocation	4.21		5		1,005
28675	2	Repair toe dislocation	2 92		5		149
28805	7	Amputation thru metatarsal	8 38	11.25	1	11 25	7,137
29075	2	Application of forearm cast	0.77	0.89	2	0.77	70,341
29580	HCPAC	Application of paste boot	0 57	0 60	1	0 60	446,399
30520	8	Repair of nasal septum	5.69	7.13	4	6 27	19,687
31225	8	Removal of upper jaw	19.20	24.00	1	24.00	802
31230	8	Removal of upper jaw	21.91	28 00	1	28 00	71
31255	8	Removal of ethmoid sinus	6.95		7		30,330
1360	8	Removal of larynx	17.05	28.00	1	28.00	668
31365	8	Removal of larynx	24.12	37 00	1	37 00	513
31367	8	Partial removal of larynx	21.83	28 00	4	27.36	74
31368	8	Partial removal of larynx	27.05	36.00	1	36.00	61
31370	8	Partial removal of larynx	21.35	25 00	1	25 00	69
31375	8	Partial removal of larynx	20.18	25.00	1	25 00	48
31380	8	Partial removal of larynx	20.18	25.00	1	25.00	28
31382	8	Partial removal of larynx	20.49	28.00	1	28 00	55
31390	8	Removal of larynx & pharynx	27.49	40 00	1	40.00	90
31395	8	Reconstruct larynx & pharynx	31.04	44.00	1	44.00	71
31575	8	Diagnostic laryngoscopy	1 10	1.53	2	1.10	500,946

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31579	8	Diagnostic laryngoscopy	2.26	2 54	2	2.26	24,241
31622	4	Dx bronchoscope/wash	2.78	2 80	2	2 78	100,186
32020	6	Insertion of chest tube	3.97		8		64,923
32095	6	Biopsy through chest wall	8 35		7		2,158
32141	6	Remove treat lung lesions	13.98	25 48	4	23 90	634
32442	6	Sleeve pneumonectomy	26 20	55.50	4	51.45	15
32445	6	Removal of lung	25 05	62 69	4	57 74	99
32484	6	Segmentectomy	20.66	25 27	4	23 25	1,320
32486	6	Sleeve lobectomy	23.88	43 94	4	39 44	120
32488	6	Complection pneumonectomy	25.67	40.97	4	38 95	179
32540	6	Removal of lung lesion	14.62	28 44	4	26.42	157
32651	6	Thoracoscopy, surgical	12.89	18 67	4	16 64	1,138
32652	6	Thoracoscopy, surgical	18.63	27 73	4	26.35	1,045
32653	6	Thoracoscopy, surgical	12.85	17 62	4	16 24	604
32654	6	Thoracoscopy, surgical	12.42	20.34	4	17 73	92
2655	6	Thoracoscopy, surgical	13.08	16 06	4	14.69	563
32657	6	Thoracoscopy, surgical	13.63	12 97	4	11 90	6,520
32662	6	Thoracoscopy, surgical	16.42	15.36	4	14.29	273
32663	6	Thoracoscopy, surgical	18 44	24.57	4	23.00	1,281
32665	6	Thoracoscopy, surgical	15.52	21.05	4	19 56	35
32815	6	Close bronchial fistula	23.12	46.99	4	42.94	174
33140	6	Heart revascularize (lmr)	19.97	32 50	4	25.49	129
33141	6	Heart lmr w/other procedure	4.83	2 43	3	2 43	1,673
33208	4	Insertion of heart pacemaker	8 12	8 12	2	8.12	131,714
33300	6	Repair of heart wound	17.89	46 05	4	40 03	267
33305	6	Repair of heart wound	21.41	74 23	4	70.21	238

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33400	6	Repair of aortic valve	28 46	40.30	4	38 33	293
33405	6	Replacement of aortic valve	34.95	39 78	4	37.82	30,407
33406	6	Repacement of aortic valve	37.44	51.14	4	49.18	621
33410	6	Replacement of aortic valve	32.41	44.87	4	42 91	1,696
33411	6	Replacement of aortic valve	36 20	63.36	4	56.91	834
33413	6	Replacement of aortic valve	43.43	63.09	4	56.19	9
33414	6	Repair of aortic valve	30.30	40 00	4	36.52	62
33415	6	Revision, subvalvular tissue	27.11	37.00	4	34 58	100
33416	6	Revise ventricule muscle	30 30	37.00	4	34.25	536
33425	6	Repair of mitral valve	26 96	52.53	4	45 97	696
33426	6	Repair of mitral valve	32.95	41 86	4	39 78	7,622
33427	6	Repair of mitral valve	39.94	44.35	4	41 82	2,815
33430	6	Replacement of mitral valve	33.45	54 05	4	46 45	11,268
33460	6	Revision of tricuspid valve	23.56	50.75	4	40.19	66
33463	6	Valvuloplasty, tricuspid	25 58	57.01	4	50 93	885
33464	6	Valvuloplasty, tricuspid	27.29	44 85	4	40.30	2,446
33465	6	Replace tricuspid valve	28 75	51.80	4	45.72	337
33474	6	Revision of pulmonary valve	23 01	39.41	4	36.39	14
33475	6	Replacement, pulmonary valve	32.95	41.76	4	39.39	60
33505	6	Repair artery w/tunnel	26.80	36.00	1	36 00	5
33510	6	CABG, vein, single-vein single	28 96	36.49	4	31 75	7,775
33511	6	CABG, vein, two	29.96	39.96	4	35.22	8,165
33512	6	CABG, vein, three	31 75	46.55	4	40 26	8,168
33513	6	CABG, vein, four	31.95	47.94	4	41 65	3,873
33514	6	CABG, vein, five	32.70	50 65	4	44.36	1,103
33516	6	Cabg, vein, six or more	34 95	52.33	4	46 04	233

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
33517	6	CABG, artery	2 57	3 36	1	3.36	20,588
33518	6	CARG, artery-vein, two	4.84	7 41	1	7 41	46,283
33519	6	CARG, artery-vein, three	7 11	9.91	1	9.91	36,938
33521	6	CARG, artery-vein, four	9 39	12 01	1	12.01	12,106
33522	6	CARG, artery-vein, five	11.65	13 53	1	13 53	2,129
33523	6	Cabg, art-vein, six or more	13 93	15 39	1	15.39	399
33530	6	Coronary artery, bypass/reop	5 85	9 78	1	9 78	15,685
33533	6	CABG, arterial, single	29.96	32.66	4	30.85	113,651
33534	6	CABG, arterial, two	32 15	38.79	4	36.98	11,647
33535	6	CABG, arterial, three	34.45	43 66	4	41 85	2,937
33536	6	Cabg, arterial, four or more	37 44	47.34	4	45.53	1,119
33542	6	Removal of heart lesion	28 81	50 28	4	44 20	1,167
33545	6	Repair of heart demage	36.72	64.12	4	52 49	159
33641	6	Repair heart septum defect	21 36	28.52	4	27.71	2,330
33665	6	Repair of heart defects	28 56	32 98	1	32.98	2
›684	6	Repair heart septum defect	29.61	32 50	1	32 50	3
33688	6	Repair heart septum defect	30 57	33.98	4	32.88	
33771	6	Repair great vessels defect	34.60	39 50	4	38 50	1
33779	6	Repair great vessels defect	36 16	42.00	4	41.00	
33781	6	Repair great vessels defect	36.40	42.00	4	41.00	1
33860	6	Ascending aortic graft	37.94	62.54	4	55.45	2,862
33863	6	Ascending aortic graft	44.93	61.85	4	55 10	1,815
33877	7	Thoracoabdominal graft	42.54	64.04	1	64.04	920
33945	6	Transplantation of heart	42.04	90.22	4	80.84	520
34001	7	Removal of artery clot	12.89	16.25	1	16 25	208
34201	7	Removal of artery clot	10.01	19.26	4	18.31	7,971

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34471	7	Removal of vein clot	10 16	20.00	1	20.00	51
35081	7	Repair defect of artery	27.97	34.55	4	31.00	7,765
35102	7	Repair defect of artery	30 71	39 80	4	36.28	5,321
35216	7	Repair blood vessel lesion	18.72	33 57	4	34.00	286
35381	7	Rechanneling of artery	15.79		5		3,092
35501	7	Artery bypass graft	19 16		5		152
35506	7	Artery bypass graft	19.64	23.75	1	23.75	83
35507	7	Artery bypass graft	19 64		5		56
35508	7	Artery bypass graft	18.62	25.00	1	25 00	20
35509	7	Artery bypass graft	18 04		5		101
35515	7	Artery bypass graft	18.62	25.00	1	25.00	6
35516	7	Artery bypass graft	16 30	23.00	1	23.00	35
35541	7	Artery bypass graft	25 76		5		96
35546	7	Artery bypass graft	25 50		5		303
35556	7	Artery bypass graft	21 73	31 58	4	27 25	6,905
35566	7	Artery bypass graft	26.88	39 20	4	32.00	6,573
35583	7	Vein bypass graft	22 34	32.26	4	26.00	3,004
35585	7	Vein bypass graft	28 35	39 42	4	32.00	4,203
35600	6	Harvest artery for cabg	4.94		7		8,942
35601	7	Artery bypass graft	17 47		5		276
35606	7	Artery bypass graft	18.68	21 00	1	21.00	755
35612	7	Artery bypass graft	15.74		7		61
35616	7	Artery bypass graft	15 68	22.00	4	21.00	72
35641	7	Artery bypass graft	24 53		5		1,052
35642	7	Artery bypass graft	17.95		7		5
35820	6	Explore chest vessels	12.86	38 76	4	32 24	7,333

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37720	7	Removal of leg vein	5 65		5		3,764
38100	7	Removal of spleen, total	14.48	19 53	4	18 00	4,133
38101	7	Removal of spleen, partial	15 29	18.00	1	18.00	45
38115	7	Repair of ruptured spleem	15 80	20 00	1	20.00	245
38700	8	Removal of lymph nodes, neck	8.23	12 00	1	12 00	918
38720	8	Removal of lymph nodes, neck	13 59	20.00	1	20.00	960
38724	8	Removal of lymph nodes, neck	14.52	22.00	1	22.00	4,620
39220	6	Removal chest lesion	17 39	19.97	4	18.40	522
39400	6	Visualization of chest	5.60	7.61	1	7 61	14,114
41100	8	Biopsy of tongue	1 63	1 54	2	1.63	6,785
41120	8	Partial removal of tongue	9.76	10.00	2	9 76	1,537
41130	8	Partial removal of tongue	11 13	14.00	1	14 00	267
41135	8	Tongue and neck surgery	23.06	27 00	1	27.00	336
41140	8	Removal of tongue	25 46	25.00	2	25.46	23
41145	8	Tongue removal, neck surgery	30 01	34 00	1	34.00	51
41150	8	Tongue, mouth, jaw surgery	23.01	26.50	1	26.50	249
41153	8	Tongue, mouth, neck surgery	23.73	34 00	1	34 00	163
41155	8	Tongue, jaw, & neck surgery	27.68	40 00	1	40 00	548
42120	8	Remove plate/lesion	6.16	11.00	1	11 00	590
42842	8	Extensive surgery of throat	8 75	11 00	1	11.00	265
42844	8	Extensive surgery of throat	14.29	16.10	1	16.10	85
42845	8	Extensive surgery of throat	24 25	32.00	1	32.00	54
42890	8	Partial removal of pharynx	12.92	17 00	1	17.00	227
42892	8	Revision of pharyngeal walls	15 81	23.09	1	23.09	133
42894	8	Revision of pharyngeal walls	22.85	30 00	1	30.00	100
43108	6	Removal of esophagus	34.14	81.36	4	76 55	27

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43113	6	Removal of esophagus	35.22	75.56	4	73 23	11
43116	6	Partial removal of esophaus	31.17	89.49	4	87 16	12
43118	6	Partial removal of esophaus	33.15	65.89	4	61.08	20
43121	6	Partial removal of esophaus	29 15	48.92	4	46 59	60
43123	6	Partial removal of esophaus	33 15	80.95	4	76 14	26
43124	6	Removal of esophagus	27.28	62 83	4	60.61	50
43135	6	Removal of esophagus pouch	16 08	25 66	4	24 20	132
43235	4	Uppr gi endoscopy, diagnosis	2 39	2.39	2	2 39	510,944
43246	4	Place gastrostomy tube	4.32	4 32	2	4.32	136,643
43496	1	Free jejunum flap, microvasc	0.00		7		24
43620	7	Removal of stomach	29 99	31.00	1	31 00	180
43621	7	Removal of stomach	30.68	39 62	4	36.00	767
43622	7	Removal of stomach	32.48	35 00	4	36 50	147
43632	7	Removal of stomach, partial	22.56	30.57	4	32 00	2,910
43633	7	Removal of stomach, partial	23 07	32 16	4	30.00	1,381
3634	7	Removal of stomach, partial	25.08	33 50	1	33.50	32
43750	4	Place gastrostomy tube	4.48	5 00	2	4.48	32,754
43820	7	Fusion of stomach and bowel	15 35	20.45	4	20 00	2,938
43840	7	Repair of stomach lesion	15 54	22.45	4	20 00	5,556
44120	7	Removal of small intenstive	16.97	23 43	4	20.11	30,806
44130	7	Bowel to bowel fusion	14.47	21 27	4	20 87	2,707
44140	7	Partial removal of colon	20.97	21.26	2	20.97	48,464
44143	7	Partial removal of colon	22 96	26.69	4	25 00	17,331
44150	7	Removal of colon	23.91	29.46	4	27.50	5,469
44151	7	Removal of colon/leostomy	26.84	31 00	4	32 00	99
44152	7	Removal of colon/leostomy	27 79		5		141

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
44153	7	Removal of colon/ileostomy	30 54		5		167
44155	7	Removal of colon/ileostomy	27.82	34.32	4	31 50	934
44156	7	Removal of colon/ileostomy	30 74	34 50	1	34.50	27
44602	7	Suture, small intestine	16.01	24.35	4	22 00	4,803
44603	7	Suture, small intestine	18 63	25.00	1	25 00	1,687
44604	7	Suture, large intestine	16 01		7		2,188
44605	7	Repair of bowel lesion	19.50		7		372
45020	7	Drainage of rectal abscess	4 71	7 75	1	7.75	637
45300	7	Proctosigmoidoscopy w/bx	0.38	0.92	4	0 91	57,539
45303	7	Proctosigmoidoscoy dilate	0 44	2 89	4	2.22	504
45305	7	Procosigmoidoscopy w/bx	1.01	2 68	4	2.01	2,219
45307	7	Proctosigmoidoscopy fb	0 94	2.89	4	2 22	151
45308	7	Proctosigmoidoscopy removal	0.83	2 68	4	2.01	280
45309	7	Proctosigmoidoscopy removal	2.01	2.89	4	2 22	229
45315	7	Proctosigmoidoscopy removal	1 40	2.89	4	2 22	110
45317	7	Proctosigmoidoscopy bleed	1.50	1 09	4	1.08	930
45320	7	Proctosigmoidoscopy ablate	1.58	3.10	4	2 43	207
45321	7	Proctosigmoidoscopy volvul	1.17	3.25	4	2 76	271
45327	7	Proctosigmoidoscopy w/slent	1.65	4 12	4	3.63	22
45330	4	Diagnostic sigmoidoscopy	0 96	1.10	2	0 96	122,925
45378	4	Diagnostic colonoscopy	3.69	3 69	2	3.69	1,143,087
46040	7	Incision of rectal abscess	4.95	4 95	2	4.95	5,767
46045	7	Incision of rectal abscess	4.31	5 50	1	5.50	338
46060	7	Incision of rectal abscess	5.68	5 68	2	5 68	1,104
46270	7	Removal of anal fistula	3.71	4 50	1	4.50	1,691
46275	7	Removal of anal fistula	4 55	5 00	1	5.00	1,218

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46280	7	Removal of anal fistula	5 97	5 97	2	5 97	1,519
46285	7	Removal of anal fistula	4 08	5.00	1	5 00	130
46600	7	Diagnostic anoscopy	0.50	0 58	4	0 49	95,217
46604	7	Anoscopy and dilation	1.31	1.09	4	1.08	1,511
46606	7	Anoscopy and biopsy	0 81	2 10	4	1.76	1,713
46608	7	Anoscopy, remove for body	1.51	2.43	4	1 95	110
46610	7	Anoscopy, remove lesion	1.32	2.65	4	1.95	284
46611	7	Anoscopy	1 81	1 09	4	1.08	176
46612	7	Anoscopy, remove lesions	2 34	2.81	4	2.14	106
46614	7	Anoscopy, control bleeding	2.01	1 09	4	1 08	1,737
46615	7	Anoscopy	2 68	1 20	4	1.18	322
46760	7	Repair of anal sphincter	14 41		7		36
46761	7	Repair of anal sphincter	13.82		7		273
46762	7	Implant artificial sphincter	12 69		7		28
47480	7	Incision of gallbladder	10.80		7		605
47490	7	Incision of gallbladder	7 22		7		3,857
47510	7	Insert catheter, bile duct	7 82		7		3,186
47511	7	Insert bile duct drain	10.48		7		5,491
47525	7	Change bile duct catheter	5.54		7		10,150
47530	7	Revise/reinsert bile tube	5.84		7		504
47562	7	Laparoscopic cholecystectomy	11 07	11 55	2	11 07	119,297
47600	7	Removal of gallbladder	13.56	17.62	4	15.88	29,510
47760	7	Fuse bile ducts and bowel	25 81	37 50	4	34.75	819
47765	7	Fuse liver ducts and bowel	24 84	48 50	1	48.50	43
47780	7	Fuse bile ducts and bowel	26 46	40.00	4	38 75	1,173
47785	7	Fuse bile ducts and bowel	31 13	51.00	4	52.50	306

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
49000	7	Exploration of abdomen	11.66		5		11,947
49002	7	Reopening of abdomen	10 47	22.35	4	15 75	4,599
49010	7	Exploration behind abdomen	12.26	16 00	4	15.00	1,646
49200	3	Removal of abdominal lesion	10.23		7		2,744
49201	3	Removal abdom lesion, complex	14.82		7		2,873
49505	7	Prp i/hern init reduc >5 yr	7 59	7.86	2	7 59	107,403
49906	1	Free omental flap, microvasc	0 00		7		3
50590	3	Fragmenting of kidney stone	9.08	10.34	2	9 08	52,828
51720	3	Treatment of bladder lesion	1 96	1 96	4	1.50	208,892
51798	3	Us urine capacity measure	0.00	0.38	1	0 38	1,174,387
52000	3	Cystoscopy	2 01	2 72	4	2 23	952,641
52204	3	Cystoscopy	2.37	3 08	4	2.59	39,733
52601	3	Prostatectomy (TURP)	12.35	15.50	4	14 00	70,777
53445	3	Insert uro/ves nck sphincter	14 04		7		1,834
54150	4	Circumcision	1 81		5		4
54152	4	Circumcision	2 31		5		310
54400	3	Insert semi-rigid prosthesis	8.98		7		444
54405	3	Insert multi-comp penis pros	13 41		7		4,133
54411	3	Remv/replc penis pros, comp	15 98		7		155
55700	3	Biopsy of prostate	1.57	2.83	4	2 58	233,082
56631	3	Extensive vulva surgery	16 18		7		257
56632	3	Extensive vulva surgery	20.26		7		219
56634	3	Extensive vulva surgery	17 85		7		77
56637	3	Extensive vulva surgery	21.94		7		239
56640	3	Extensive vulva surgery	22.14		7		18
57160	3	Insert pessary/other device	0 89	1.60	2	0 89	111,204

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57240	3	Repair bladder & vagina	6 06	10.90	4	10.56	14,024
57250	3	Repair rectum & vagina	5.52	10.75	4	10.56	9,539
57260	3	Repair vagina	8.26	16 28	4	13 50	17,038
57265	3	Extensive repair of vagina	11.32	19.34	4	15 00	6,676
57288	3	Repair bladder defect	13 00	13.00	2	13.00	38,242
57500	3	Biopsy of cervix	0.97	1.35	4	1.20	9,266
57550	3	Removal of residual cervix	5 52		7		34
57555	3	Remove cervix/repair vagina	8.94		7		40
57556	3	Remove cervix, repair bowel	8 36		7		179
58120	3	Dilation and curettage	3.27	3.27	2	3.27	19,325
58150	3	Total hysterectomy	15 22	18.00	4	15 98	24,214
58260	3	Vaginal hysterectomy	12.96		7		9,651
58720	3	Removal of ovary/tube(s)	11.34	11.34	2	11.34	8,593
60600	7	Remove carotid body lesion	17.90	24.00	1	24.00	119
60605	7	Remove carotid body lesion	20 21	30.50	1	30 50	32
61154	3	Pierce skull & remove clot	14.97	14.97	2	14.97	8,547
61312	3	Open skull for drainage	24 53	27.00	1	27 00	9,350
61537	3	Removal of brain tissue	24.96	35.00	1	35.00	115
61538	3	Removal of brain tissue	26.77	38.00	1	38.00	109
61697	3	Brain aneurysm repr, complx	50.44	61.48	4	57.31	781
61698	3	Brain aneurysm repr, complx	48.34	65.00	4	64.03	60
61700	3	Brain aneurysm repr, simple	50.44	52.00	4	46 01	1,181
61702	3	Inner skull vessel surgery	48.34	60 00	4	54.28	44
62270	4	Spinal fluid tap, diagnostic	1 13	1.65	4	1 37	78,870
62350	3	Implant spinal canal cath	6 86		7		6,315
62351	3	Implant spinal canal cath	9.99		7		355

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62355	3	Removal spinal canal catheter	5 44		7		1,258
62360	3	Insert spine infusion device	2.62		7		443
62361	3	Implant spine infusion pump	5 41		7		231
62362	3	Implant spinal infusion pump	7.03		7		5,020
62365	3	Removal spine infusion device	5 41		7		1,155
63047	3	Removal of spinal lamina	14.59	14 08	3	14.08	75,647
63048	3	Remove spinal lamina add-on	3 26	3.60	4	3.55	118,656
63075	3	Neck spine disk surgery	19 38	18.58	3	18.58	19,930
63650	3	Implant neuroelectrodes	6 73		7		10,255
63655	3	Implant neuroelectrodes	10 27		7		1,306
63660	3	Revise/remove neuroelectrode	6 15		7		3,341
63685	3	Insrt/redo spine n generator	7.03		7		3,610
63688	3	Revise/remove neuroreceiver	5 38		7		2,658
64550	3	Apply neurostimulator	0 18		7		24,727
64553	3	Implant neuroelectrodes	2 31		7		60
64555	3	Implant neuroelectrodes	2.27		7		1,990
64560	3	Implant neuroelectrodes	2.36		7		7
64561	3	Implant neuroelectrodes	6.73		7		1,406
64565	3	Implant neuroelectrodes	1 76		7		964
64573	3	Implant neuroelectrodes	7 49		7		1,183
64575	3	Implant neuroelectrodes	4.34		7		209
64577	3	Implant neuroelectrodes	4.61		7		13
64580	3	Implant neuroelectrodes	4.11		7		27
64581	3	Implant neuroelectrodes	13.48		7		2,433
64585	3	Revise/remove neuroelectrode	2.06		7		1,078
64590	3	Insrt/redo perph n generator	2 40		7		2,005

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64595	3	Revise/remove neuroreceiver	1.73		7		579
64702	2	Revise finger/toe nerve	4 22	6.00	4	5.52	768
64721	2	Carpal tunnel surgery	4 28	5.00	2	4.28	114,443
65420	8	Removal of eye lesion	4 16	4.80	7		5,531
65426	8	Removal of eye lesion	5 24	6.58	4	5.85	4,706
65850	8	Incision of eye	10 50	11 93	4	11.14	338
65900	8	Remove eye lesion	10 91		7		100
66761	8	Revision of iris	4 06	4 06	2	4 06	85,708
66821	8	After cataract laser surgery	2.35	3 00	4	2.78	675,728
66984	8	Cataract surg w/iol, 1 stage	10 21	10.21	4	9 78	1,802,958
67038	8	Strip retinal membrane	21 21	21 21	5		52,260
67221	8	Ocular photodynamic ther	4.00	4.00	4	3.45	126,894
67228	8	Treatment of retinal lesion	12.72	12.72	5		110,068
67414	8	Explr/decompress eye socket	11 11	16.82	1	16.82	318
67445	8	Explr/decompress eye socket	14.40	18 00	1	18.00	222
67500	8	Inject/treat eye socket	0 79	1.44	1	1 44	16,121
67505	8	Inject/treat eye socket	0 82	1 27	1	1 27	1,210
67515	8	Inject/treat eye socket	0.61	1.40	1	1.40	35,076
67820	8	Revise eyelashes	0 89	0.71	3	0 71	285,124
67840	8	Remove eyelid lesion	2 04	2 04	2	2 04	49,843
67904	8	Repair eyelid defect	6.25	7 50	1	7.50	56,300
67911	8	Revise eyelid defect	5 26	7.30	1	7 30	2,790
67917	8	Repair eyelid defect	6 01		7		24,133
67924	8	Repair eyelid defect	5.78		7		11,210
67966	8	Revision of eyelid	6.56	8 50	1	8.50	5,926
68750	8	Create tear duct drain	8.65		7		873

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
68840	8	Explore/irrigate tear ducts	1 25	1.25	2	1.25	37,656
69210	8	Remove impacted ear wax	0.61	0.82	2	0 61	1,322,628
70355	4	Panoramic x-ray of jaws	0.20	0 22	2	0.20	28,678
71010	4	Chest x-ray	0.18	0 18	2	0 18	18,282,814
71020	4	Chest x-ray	0.22	0.22	2	0 22	15,676,163
71260	4	Ct thorax w/dye	1 24	1 30	2	1.24	1,971,811
72192	4	Ct pelvis w/o dye	1.09	1.11	2	1 09	1,222,624
72193	4	Ct pelvis w/dye	1.16	1.20	2	1.16	2,308,971
73100	4	X-ray exam of wrist	0.16	0 16	2	0.16	458,439
73110	4	X-ray exam of wrist	0.17	0.17	2	0 17	753,523
73120	4	X-ray exam of hand	0 16	0.16	2	0 16	296,490
73130	4	X-ray exam of hand	0.17	0 17	2	0.17	755,783
73140	4	X-ray exam of finger(s)	0 13	0 13	2	0.13	310,708
74000	4	X-ray exam of abdomen	0 18	0.18	2	0.18	1,838,163
74020	4	X-ray exam of abdomen	0.27	0.27	2	0 27	994,189
4022	4	X-ray exam series, abdomen	0 32	0 32	2	0 32	1,089,991
74150	4	Ct abdomen w/o dye	1 19	1.23	2	1.19	1,315,665
74160	4	Ct abdomen w/dye	1.27	1.35	2	1 27	2,145,140
75552	4	Heart mri for morph w/o dye	1 60	2.23	5		1,205
75553	4	Heart mri for morph w dye	2 00	2 75	5		2,050
75554	4	Cardiac MRI/function	1.83	2.63	5		3,629
75555	4	Cardiac MRI/limited study	1 74	2.00	5		490
76075	4	Dxa bone density, axial	0.30	0 30	4	0.20	2,426,361
76519	8	Echo exam of eye	0.54	0 54	2	0 54	1,322,402
76700	4	Us exam, abdom, complete	0.81	0.81	2	0 81	1,329,410
76830	4	Transvaginal us, non-ob	0 69	0.69	2	0.69	325,124

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
77263	4	Radiation therapy planning	3 14	3.14	2	3.14	276,554
77280	4	Set radiation therapy field	0.70	0 70	2	0 70	240,934
77290	4	Set radiation therapy field	1 56	1.56	2	1 56	348,188
77300	4	Radiation therapy dose plan	0.62	0 62	2	0.62	1,282,101
77315	4	Teletx isodose plan complex	1.56	1 56	2	1 56	152,581
77331	4	Special radiation dosimetry	0 87	0 87	2	0.87	321,893
77334	4	Radiation treatment aid(s)	1.24	1.24	2	1 24	1,087,833
77470	4	Special radiation treatment	2.09	2 09	2	2.09	139,703
78306	4	Bone imaging, whole body	0.86	0 86	2	0 86	722,160
78315	4	Bone imaging, 3 phase	1 02	1.02	2	1.02	139,583
78465	4	Heart image (3d), multiple	1.46	1 46	2	1.46	2,930,407
78478	4	Heart wall motion add-on	0 62	0.62	4	0 50	2,765,566
78480	4	Heart function add-on	0.62	0 62	4	0.30	2,766,786
88309	4	Tissue exam by pathologist	2.28	3.00	4	2.80	200,175
88321	4	Microslide consultation	1.30	2 00	4	1.63	155,079
8323	4	Microslide consultation	1 35	2 31	4	1 83	34,714
88325	4	Comprehensive review of data	2.22	2 93	4	2.50	21,487
90465	4	Immune admin 1 inj, < 8 yrs	0.17		5		
90466	4	Immune admin addl inj, < 8 y	0.15		5		
90467	4	Immune admin o or n, < 8 yrs	0 00		5		
90468	4	Immune admin o/n, addl , < 8 y	0.00		5		
90473	4	Immune admin oral/nasal	0.00		7		
90474	4	Immune admin oral/nasal addl	0.00		7		
92083	8	Visual field examination(s)	0.50	0.60	2	0.50	2,434,073
92226	8	Special eye exam, subsequent	0.33	0 33	2	0.33	1,965,033
92235	8	Eye exam with photos	0 81	0.81	2	0.81	1,560,890

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
92250	8	Eye exam with photos	0.44	0 44	2	0 44	1,697,307
92506	8	Speech/hearing evaluation	0.86		7		11,395
92507	8	Speech/hearing therapy	0.52		7		18,376
92508	8	Speech/hearing therapy	0 26		7		711
92510	8	Rehab for ear implant	1.50		7		
92516	8	Facial nerve function test	0 43		7		419
92520	8	Laryngeal function studies	0 76		7		4,107
92526	8	Oral function therapy	0.55		7		4,962
92541	8	Spontaneous nystagmus test	0 40		7		143,644
92542	8	Positional nystagmus test	0.33		7		162,083
92543	8	Caloric vestibular test	0 10		7		445,808
92544	8	Optokinetic nystagmus test	0 26		7		134,220
92545	8	Oscillating tracking test	0.23		7		203,750
92546	8	Sinusoidal tracking test	0.29		7		182,055
92547	8	Supplemental electrical test	0.00		7		323,605
2548	8	Posturography	0.50		7		18,389
92551	8	Pure tone hearing test, air	0 00		7		1
92552	8	Pure tone audiometry, air	0.00		7		114,258
92553	8	Audiometry, air & bone	0.00		7		56,641
92555	8	Speech threshold audiometry	0 00		7		14,940
92556	8	Speech threshold, complete	0.00		7		30,566
92557	8	Comprehensive hearing test	0.00		7		1,024,287
92559	8	Group audiometric testing	0.00		7		
92560	8	Bekesy audiometry, screen	0.00		7		
92561	8	Bekesy audiometry, diagnosis	0.00		7		3,578
92562	8	Loudness balance test	0 00		7		3,465

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
92563	8	Tone decay hearing test	0.00		7		30,073
92564	8	Sisi hearing test	0.00		7		3,223
92565	8	Stenger test, pure tone	0 00		7		2,631
92567	8	Tympanometry	0.00		7		890,065
92568	8	Acoustic reflex testing	0.00		7		332,191
92569	8	Acoustic reflex decay test	0 00		7		61,234
92571	8	Filtered speech hearing test	0.00		7		1,735
92572	8	Staggered spondaic word test	0 00		7		141
92573	8	Lombard test	0 00		7		
92575	8	Sensorineural acuity test	0.00		7		893
92576	8	Synthetic sentence test	0 00		7		222
92579	8	Visual audiometry (vra)	0 00		7		1,041
92582	8	Conditioning play audiometry	0.00		7		916
92583	8	Select picture audiometry	0 00		7		293
92584	8	Electrocochleography	0 00		7		14,715
2585	8	Auditor evoke potent, compre	0 50		7		50,994
92586	8	Auditor evoke potent, limit	0 00		7		438
92587	8	Evoked auditory test	0.13		7		25,416
92588	8	Evoked auditory test	0.36		7		69,019
92596	8	Ear protector evaluation	0 00		7		55
92597	8	Oral speech device eval	0.86		7		1,856
92601	8	Cochlear implt f/up exam < 7	0.00		7		3
92602	8	Reprogram cochlear implt <7	0.00		7		3
92603	8	Cochlear implt f/up exam 7>	0.00		7		857
92604	8	Reprogram cochlear implt 7 >	0.00		7		6,923
92605	8	Eval for nonspeech device rx	0.00		7		

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
92606	8	Non-speech device service	0.00		7		
92607	8	Ex for speech device rx, 1 hr	0.00		7		151
92608	8	Ex for speech device rx, addl	0 00		7		92
92609	8	Use of speech device service	0 00		7		159
92610	8	Evaluate swallowing function	0 00		7		3,313
92611	8	Motion fluoroscopy/swallow	0.00		7		3,543
92612	8	Endoscopy swallow tst (fees)	1 27		7		1,796
92614	8	Laryngoscopic sensory test	1.27		7		371
92616	8	Fees w/laryngeal sense test	1 88		7		1,857
92620	8	Auditory functon, 60 min	0.00		7		
92621	8	Auditory function, + 15 min	0.00		7		
92625	8	Tinnitus assessment	0.00		7		
93010	4	Electrocardiogram report	0.17	0 24	2	0.17	19,204,537
93015	4	Cardiovascular stress test	0.75	1.00	2	0.75	2,252,974
93018	4	Cardiovascular stress test	0 30	0 60	2	0.30	1,503,471
3325	4	Doppler color flow add-on	0.07	0.30	5		6,631,110
94010	4	Breathing capacity test	0.17	0.17	2	0 17	1,237,293
94657	4	Continued ventilator mgmt	0 83	1.37	5		309,199
95004	4	Percut allergy skin tests	0.00	0.03	5		11,262,370
95024	4	Id allergy test, drug/bug	0 00	0 04	5		3,417,111
95027	4	Id allergy titrate-airborne	0.00	0.03	5		349,204
95115	4	Immunotherapy, one injection	0.00	0.10	7		1,532,305
95117	4	Immunotherapy injections	0 00	0 10	7		1,728,170
95144	4	Antigen therapy services	0.06	0.12	2	0 06	303,805
95165	4	Antigen therapy services	0 06	0 12	2	0.06	6,017,763
95816	4	Eeg, awake and drowsy	1.08	1.08	2	1 08	228,893

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95819	4	Eeg, awake and asleep	1.08	1 29	2	1 08	389,584
95861	4	Muscle test, 2 limbs	1 54	1.68	2	1.54	295,258
95872	4	Muscle test, one fiber	1.50	3.00	1	3 00	909
95900	4	Motor nerve conduction test	0.42	0 55	2	0 42	1,365,558
95904	4	Sense nerve conduction test	0 34	0.55	2	0.34	2,749,528
95925	4	Somatosensory testing	0 54	0.79	2	0.54	44,977
95926	4	Somatosensory testing	0.54	0.79	2	0 54	68,412
95927	4	Somatosensory testing	0.54	1.00	2	0.54	2,953
95953	4	EEG monitoring/computer	3 08	3.50	4	3 30	9,284
96105	HCPAC	Assessment of aphasia	0.00		7		519
96567	1	Photodynamic tx, skin	0 00	1 30	7		4,794
97802	HCPAC	Medical nutrition, indiv in	0 00		5		160,685
97803	HCPAC	Med nutrition, indiv, subseq	0.00		5		81,867
97804	HCPAC	Medical nutrition, group	0.00		5		6,406
99201	5	Office/outpatient visit, new	0.45	0.45	2	0.45	465,665
9202	5	Office/outpatient visit, new	0 88	0.88	2	0 88	2,742,495
99203	5	Office/outpatient visit, new	1 34	1.92	2	1.34	5,007,937
99204	5	Office/outpatient visit, new	2.00	2 78	4	2.30	3,201,161
99205	5	Office/outpatient visit, new	2.67	3.78	4	3.00	1,097,515
99211	5	Office/outpatient visit, est	0 17	0 17	2	0.17	10,445,542
99212	5	Office/outpatient visit, est	0 45	0.62	2	0.45	26,139,270
99213	5	Office/outpatient visit, est	0.67	1.40	6		111,261,211
99214	5	Office/outpatient visit, est	1.10	2 00	6		55,174,565
99215	5	Office/outpatient visit, est	1.77	2 70	6		6,953,937
99221	5	Initial hospital care	1.28	2.56	4	1 88	518,754
99222	5	Initial hospital care	2 14	3.43	4	2 56	3,486,006

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99223	5	Initial hospital care	2.99	4 26	4	3 78	5,721,509
99231	5	Subsequent hospital care	0 64	1.00	4	0.76	20,534,153
99232	5	Subsequent hospital care	1.06	2.02	4	1.30	50,336,836
99233	5	Subsequent hospital care	1.51	3 03	4	2 00	17,225,862
99238	5	Hospital discharge day	1.28	1.50	2	1.28	6,416,301
99239	5	Hospital discharge day	1.75	2.30	4	1.90	2,279,088
99241	5	Office consultation	0.64	1 00	2	0.64	456,792
99242	5	Office consultation	1.29	1.58	4	1.34	1,767,974
99243	5	Office consultation	1.72	2 01	4	1.88	4,897,411
99244	5	Office consultation	2.58	3.02	4	3.02	5,512,793
99245	5	Office consultation	3.42	4.00	4	3 77	2,122,524
99251	5	Initial inpatient consult	0.66	1 15	4	1 00	366,384
99252	5	Initial inpatient consult	1.32	1.81	4	1.50	1,157,331
99253	5	Initial inpatient consult	1.82	2.50	4	2 27	3,391,552
99254	5	Initial inpatient consult	2 64	3 50	4	3.29	5,626,795
9255	5	Initial inpatient consult	3.64	4.50	4	4.00	2,817,081
99281	5	Emergency dept visit	0 33	0.50	4	0.45	178,635
99282	5	Emergency dept visit	0.55	1 00	4	0.88	1,095,199
99283	5	Emergency dept visit	1.24	2.00	4	1.34	5,159,423
99284	5	Emergency dept visit	1.95	3.14	4	2.56	5,520,136
99285	5	Emergency dept visit	3 06	4.19	4	3.80	6,534,826
99291	5	Critical care, first hour	3.99	5 10	4	4.29	2,960,371
99292	5	Critical care, addl 30 min	2.00	2.66	4	2.15	340,790
99301	5	Nursing facility Care	1 20		5		288,654
99302	5	Nursing facility Care	1 61		5		583,581
99303	5	Nursing facility Care	2.01		5		1,219,830

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99311	5	Nursing fac care, subseq	0.60		5		5,679,807
99312	5	Nursing fac care, subseq	1.00		5		9,791,724
99313	5	Nursing fac care, subseq	1.42		5		3,362,540
99321	5	Rest home visit, new patient	0.71		5		40,365
99322	5	Rest home visit, new patient	1.01		5		48,948
99323	5	Rest home visit, new patient	1 28		5		45,005
99331	5	Rest home visit, est patient	0.60		5		347,932
99332	5	Rest home visit, est patient	0.80		5		626,373
99333	5	Rest home visit, est patient	1.00		5		275,125
G0270	HCPAC	MNT subs tx for change dx	0.00		5		2,272
G0271	HCPAC	Group MNT 2 or more 30 mins	0.00		5		259

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2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
00797	Anesth, surgery for obesity	8,521	4	N/A	1	30			185	30													245	8.00	11.00
11100	Biopsy, skin lesion	1,981,129	1	0	2	5			12	5													22	0.81	0.81
11400	Exc tr-ext b9+marg 0.5 < cm	58,652	1	10	2	5			10	5									1				35	0 85	0.85
11401	Exc tr-ext b9+marg 0.6-1 cm	103,548	1	10	2	10			20	5									1				50	1 23	1.23
11402	Exc tr-ext b9+marg 1.1-2 cm	123,031	1	10	4	10			25	5									1				55	1 51	1 40
11403	Exc tr-ext b9+marg 2.1-3 cm	58,319	1	10	2	10	5	5	30	10									1				75	1 79	1 79
11404	Exc tr-ext b9+marg 3.1-4 cm	23,393	1	10	2	10	5	5	40	10									1				85	2 06	2 06
11406	Exc tr-ext b9+marg > 4.0 cm	23,256	1	10	4	10	5	5	60	10										1			113	2 76	3 20
11420	Exc h-f-nk-sp b9+marg 0.5 <	37,395	1	10	2	5			10	5									1				35	0 98	0.98
11421	Exc h-f-nk-sp b9+marg 0.6-1	49,725	1	10	2	10			20	5									1				50	1.42	1.42
11422	Exc h-f-nk-sp b9+marg 1.1-2	51,753	1	10	2	10			25	5									1				55	1.63	1.63
11423	Exc h-f-nk-sp b9+marg 2.1-3	22,012	1	10	2	10	5	5	30	10									1				75	2.01	2 01
11424	Exc h-f-nk-sp b9+marg 3 1-4	7,718	1	10	2	10	5	5	40	10									1				85	2.43	2.43
11426	Exc h-f-nk-sp b9+marg > 4 cm	5,430	1	10	2	10	5	5	60	10										1			113	3.77	3.77
11440	Exc face-mm b9+marg 0.5 < cm	71,485	1	10	4	5			10	5									1				35	1 06	1 00
11441	Exc face-mm b9+marg 0.6-1 cm	79,679	1	10	2	10			20	5									1				50	1 48	1 48
11442	Exc face-mm b9+marg 1.1-2 cm	61,434	1	10	2	10			25	5									1				55	1 72	1 72
11443	Exc face-mm b9+marg 2.1-3 cm	18,269	1	10	2	10	5	5	30	10									1				75	2 29	2 29
11444	Exc face-mm b9+marg 3.1-4 cm	5,200	1	10	2	10	5	5	40	10									1				85	3 14	3.14
11446	Exc face-mm b9+marg > 4 cm	2,738	1	10	2	10	5	5	60	10										1			113	4 48	4.48
11600	Exc tr-ext mlg+marg 0 5 < cm	9,023	1	10	2	10			10	5										1			48	1 31	1.31
11601	Exc tr-ext mlg+marg 0 6-1 cm	39,378	1	10	4	15			20	5										1			63	1 80	1.75
11602	Exc tr-ext mlg+marg 1.1-2 cm	121,520	1	10	2	15			25	5										1			68	1.95	1.95
11603	Exc tr-ext mlg+marg 2.1-3 cm	61,629	1	10	4	20	5	5	30	10										1			93	2.19	2.50
11604	Exc tr-ext mlg+marg 3.1-4 cm	24,581	1	10	4	20	5	5	40	10										1			103	2.40	2.85
11606	Exc tr-ext mlg+marg > 4 cm	22,555	1	10	4	20	5	5	90	10										1			153	3.42	4.70
11620	Exc h-f-nk-sp mlg+marg 0 5 <	4,813	1	10	4	10			10	5										1			48	1.19	1.32
11621	Exc h-f-nk-sp mlg+marg 0 6-1	21,521	1	10	2	15			20	5										1			63	1.76	1.76
11622	Exc h-f-nk-sp mlg+marg 1 1-2	53,607	1	10	2	15			25	5										1			68	2 09	2 09
11623	Exc h-f-nk-sp mlg+marg 2.1-3	23,235	1	10	4	20	5	5	30	10										1			93	2 61	2.79
11624	Exc h-f-nk-sp mlg+marg 3.1-4	8,418	1	10	4	20	5	5	40	10										1			103	3.06	3.30
11626	Exc h-f-nk-sp mlg+mar > 4 cm	7,033	1	10	2	20	5	5	60	10										1			123	4.29	4.29
11640	Exc face-mm malig+marg 0.5 <	26,146	1	10	2	10			10	5										1			48	1.35	1.35
11641	Exc face-mm malig+marg 0 6-1	93,199	1	10	4	15			20	5										1			63	2.16	1.85
11642	Exc face-mm malig+marg 1 1-2	152,434	1	10	4	15			25	5										1			68	2 59	2 30
11643	Exc face-mm malig+marg 2.1-3	50,764	1	10	2	20	5	5	30	10										1			93	3 10	3 10
11644	Exc face-mm malig+marg 3.1-4	16,480	1	10	2	20	5	5	45	10										1			108	4.02	4.02
11646	Exc face-mm mlg+marg > 4 cm	10,275	1	10	2	20	5	5	65	10										1			128	5.94	5.94
12052	Layer closure of wound(s)	73,449	1	10	2	5			28	10									2				73	2 77	2.77
13121	Repair of wound or lesion	47,763	1	10	2	10			60	15									2				115	4.32	4 32
14040	Skin tissue rearrangement	75,938	1	90	2	15	10	5	90	25									2	2			221	7 86	7 86
14060	Skin tissue rearrangement	89,343	1	90	2	15	10	5	60	15									2	2			181	8.49	8 49
15100	Skin split graft	21,432	1	90	2	45	10	10	60	20			1			1			2	2			276	9.04	9 04
15240	Skin full graft	11,260	1	90	2	45	10	10	60	20						1			2	4			285	9.03	9.03
15734	Muscle-skin graft, trunk	12,638	1	90	2	30	15	15	163	30			1	1	1	1			2	2	1		493	17.76	17.76
17003	Destroy lesions, 2-14	14,967,497	1	ZZZ	4				2														2	0.15	0.07
17262	Destruction of skin lesions	155,455	1	10	2	5	3		15	5									1				43	1.58	1.58

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17281	Destruction of skin lesions	149,754	1	10	2	5	3		14	5								1					42	1 72	1.72
19180	Removal of breast	15,560	7	90	4	30	15	15	90	20			1			1			2	1			309	8.79	14.67
20600	Drain/inject, joint/bursa	363,057	2	0	2	10	2	2	5	5													24	0.66	0 66
20610	Drain/inject, joint/bursa	4,532,254	2	0	2	7			15	7													29	0.79	0 79
20680	Removal of support implant	50,794	2	90	4	35	15	15	50	15						0 5			2					178	3.34	5 86
21145	Reconstruct midface, lefort	12	1	90	4	43			202	64			2			1				6			511 5	19.91	21 84
21146	Reconstruct midface, lefort	2	1	90	4	46			227	67			2			1				6 5			563.5	20.68	22.55
21147	Reconstruct midface, lefort	3	1	90	4	46			252	67	1 5		3			1				6 5			692.5	21.74	23.32
21395	Treat eye socket fracture	15	1	90	4	30	15	15	120	30			1	1		1			1	1			333	12.66	13.88
22520	Percut vertebroplasty thor	13,992	3	10	2	30	15	15	45	30						0 5				1			176	8 90	8.90
22554	Neck spine fusion	24,477	3	90	3	60	20	15	90	30				1		1				3			350	18 59	16.40
22612	Lumbar spine fusion	43,306	3	90	4	60	20	15	150	30			1	2		1				3			459	20 97	22.00
22840	Insert spine fixation device	15,975	3	ZZZ	2				60														60	12 52	12.52
24363	Replace elbow joint	1,013	2	90	4	50	17.5	15	150	30			2	1		1			1	3			450 5	18 46	21.07
24430	Repair of humerus	641	2	90	4	30	18	15	102	15			2			1			1	3			338	12 79	14.00
25447	Repair wrist joint(s)	8,991	2	90	2	20	15	10	100	20						0 5			3	2			274	10.35	10.35
26055	Incise finger tendon sheath	59,370	2	90	2	20	15	5	20	20						0 5			2	1			151	2.69	2.69
26160	Remove tendon sheath lesion	12,971	2	90	2	20	15	5	20	20						0 5			2	1			151	3.15	3.15
26600	Treat metacarpal fracture	16,336	2	90	1	7	2	0	15	5									4				89	1.96	2.40
26951	Amputation of finger/thumb	7,509	2	90	4	20	15	5	30	20						0 5			3	2			199	4 58	5.25
27130	Total hip arthroplasty	106,878	2	90	2	60	15	15	135	30			3	1		1			1	3			462	20 09	20.09
27236	Treat thigh fracture	84,217	2	90	2	60	15	15	90	30			3	2		1			1	3			447	15 58	15 58
27447	Total knee arthroplasty	246,836	2	90	2	45	15	15	124	30			3	1		1			1	2	1		451	21.45	21.45
27465	Shortening of thigh bone	26	2	90	1	33	20	13	120	23			3			1			2	2			378	13.85	17.50
27470	Repair of thigh	612	2	90	2	30	10	15	120	20			2	1		1			4	1			382	16.05	16 05
27709	Incision of tibia & fibula	161	2	90	4	40	18	10	108	15			2			1			2	2			341	9.94	16 50
27880	Amputation of lower leg	20,589	7	90	1	30	15	15	80	20			5	1		1			1	2			382	11 83	13.75
28805	Amputation thru metatarsal	7,137	7	90	1	30	15	15	60	20			6			1			2	2			366	8 38	11.25
29075	Application of forearm cast	70,341	2	0	2	10	2	3	10														25	0.77	0.77
30520	Repair of nasal septum	19,687	8	90	4	13.5	10	15	60	15						0 5			2	2			207 5	5.69	6.27
31225	Removal of upper jaw	802	8	90	1	45	15	20	180	30			1	2	1	1 0			1	3	1		568	19 20	24.00
31230	Removal of upper jaw	71	8	90	1	60	15	20	225	30			2	2	1	1 0			1	3	1		647	21 91	28 00
31360	Removal of larynx	668	8	90	1	60	15	20	200	35			3	3	1	1 0			1	3	2		714	17.05	28.00
31365	Removal of larynx	513	8	90	1	60	15	20	300	40			4	3	1	1 0			1	3	2		838	24.12	37.00
31367	Partial removal of larynx	74	8	90	4	60	15	20	180	35			2	3	1	1 0			1	3	2		675	21.83	27 36
31368	Partial removal of larynx	61	8	90	1	60	15	20	285	40			3	3	1	1 0			1	3	2		804	27.05	36.00
31370	Partial removal of larynx	69	8	90	1	60	15	20	180	35			2	3	1	1 0			1	3	2		675	21.35	25 00
31375	Partial removal of larynx	48	8	90	1	60	15	20	150	35			2	3	1	1 0			1	3	2		645	20.18	25.00
31380	Partial removal of larynx	28	8	90	1	60	15	20	160	35			2	3	1	1 0			1	3	2		655	20.18	25.00
31382	Partial removal of larynx	55	8	90	1	60	15	20	180	35			2	3	1	1 0			1	3	2		675	20 49	28 00
31390	Removal of larynx & pharynx	90	8	90	1	60	15	20	360	40			3	3	2	1 0			1	3	2		920	27 49	40 00
31395	Reconstruct larynx & pharynx	71	8	90	1	60	15	20	400	40			4	3	2	1 0			1	3	2		979	31 04	44 00
31575	Diagnostic laryngoscopy	500,946	8	0	2	5	5	5	8	5													28	1 10	1 10
31579	Diagnostic laryngoscopy	24,241	8	0	2	10	5	0	15	15													45	2.26	2.26
31622	Dx bronchoscope/wash	100,186	4	0	2	10	5	5	30	15													65	2.78	2.78
32141	Remove/treat lung lesions	634	6	90	4	60	15	20	116	40			1	4	3	1			1	1			587	13 98	23.90
32442	Sleeve pneumonectomy	15	6	90	4	60	15	20	286	60			1	4	6	1				2			908	26 20	51.45

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32445	Removal of lung	99	6	90	4	60	15	20	310	40	1		1	4	6	1		1	1	2			1043	25 05	57.74
32484	Segmentectomy	1,320	6	90	4	60	15	20	139	40			1	2	2	1		1	1				509	20 66	23.25
32486	Sleeve lobectomy	120	6	90	4	60	15	20	240	40			1	3	4	1		1	1				722	23 88	39 44
32488	Completion pneumonectomy	179	6	90	4	60	15	20	194	40	1		1	2	4	1		1	1	1			747	25.67	38.95
32540	Removal of lung lesion	157	6	90	4	60	15	20	120	40			1	5	3	1		1	2				644	14.62	26.42
32651	Thoracoscopy, surgical	1,138	6	90	4	60	15	20	70	40			1	5		1		1	1				448	12.89	16.64
32652	Thoracoscopy, surgical	1,045	6	90	4	60	15	20	160	40			1	3	2	1		1	2				583	18.63	26.35
32653	Thoracoscopy, surgical	604	6	90	4	60	15	20	77	40			2	4		1		1	1				444	12.85	16 24
32654	Thoracoscopy, surgical	92	6	90	4	10	12	15	71	40			1	4	2	1		1	1				443	12.42	17 73
32655	Thoracoscopy, surgical	563	6	90	4	60	15	20	73	40			1	3		1		1	1				391	13 08	14 69
32657	Thoracoscopy, surgical	6,520	6	90	4	60	15	20	60	40				2		1		1	1				329	13 63	11.90
32662	Thoracoscopy, surgical	273	6	90	4	60	15	20	98	40				1		1		1	1				337	16 42	14 29
32663	Thoracoscopy, surgical	1,281	6	90	4	60	15	20	145	40			1	2	1	1		1	1				474	18 44	23 00
32665	Thoracoscopy, surgical	35	6	90	4	60	15	20	105	40			1	3	1	1		1	1				464	15 52	19 56
32815	Close bronchial fistula	174	6	90	4	60	15	20	155	40	1		1	7	6	1		1	1	2			978	23.12	42.94
33140	Heart revascularize (tmr)	129	6	90	4	60	15	20	113	40	1		1	1	3	1				1			557	19.97	25 49
33141	Heart tmr w/other procedure	1,673	6	ZZZ	3				19		0 11				0								30.03	4 83	2 43
33208	Insertion of heart pacemaker	131,714	4	90	2	15	15	15	60	30													135	8 12	8 12
33300	Repair of heart wound	267	6	90	4	10	12	15	144	40	3	1	1	2	4	1				1			759	17.89	40.03
33305	Repair of heart wound	238	6	90	4	10	12	15	296	40	6	2	1	2	4	1				1			1132	21.41	70.21
33400	Repair of aortic valve	293	6	90	4	60	15	20	211	40	1		1	1	3	1				1	1		678	28.46	38 33
33405	Replacement of aortic valve	30,407	6	90	4	60	15	20	198	40	1		1	2	3	1				1	1		695	34.95	37.82
33406	Replacement of aortic valve	621	6	90	4	60	15	20	282	40	1		1	2	3	1				1	1		779	37.44	49.18
33410	Replacement of aortic valve	1,696	6	90	4	60	15	20	229	40	1		1	2	3	1				1	1		726	32 41	42.91
33411	Replacement of aortic valve	834	6	90	4	60	15	20	283	40	2		1	4	4	1				1	1		944	36 20	56.91
33413	Replacement of aortic valve	9	6	90	4	60	15	20	297	40	2		1	1	3	1				1	1		827	43.43	56 19
33414	Repair of aortic valve	62	6	90	4	60	15	15	240	60	1		1	1	3	1					1		699	30.30	36.52
33415	Revision, subvalvular tissue	100	6	90	4	60	15	20	186	40	1		1	2	2	1					1		619	27 11	34 58
33416	Revise ventricle muscle	536	6	90	4	60	18	15	205	60	1		2	1	1	1				1	1		627	30 30	34 25
33425	Repair of mitral valve	696	6	90	4	60	15	20	254	40	1		1	2	4	1				1	1		792	26.96	45 97
33426	Repair of mitral valve	7,622	6	90	4	60	15	20	205	40	1		1	2	3	1				1	1		702	32.95	39.78
33427	Repair of mitral valve	2,815	6	90	4	60	15	20	221	40	1		1	2	2	1				1	1		677	39 94	41.82
33430	Replacement of mitral valve	11,268	6	90	4	60	15	20	223	40	2		1	2	3		1			2	1		815	33 45	46.45
33460	Revision of tricuspid valve	66	6	90	4	60	15	20	164	40	1		1	3	5	1					1		750	23.56	40 19
33463	Valvuloplasty, tricuspid	885	6	90	4	60	15	20	231	40	2		1	7	4	1				1	1		982	25.58	50.93
33464	Valvuloplasty, tricuspid	2,446	6	90	4	60	15	20	205	40	1		1	3	4	1				1	1		773	27 29	40 30
33465	Replace tricuspid valve	337	6	90	4	60	15	20	211	40	2		1	5	3	1				1	1		861	28.75	45 72
33474	Revision of pulmonary valve	14	6	90	4	60	15	20	222	40	1		1	2	2	1				1	1		678	23.01	36.39
33475	Replacement, pulmonary valve	60	6	90	4	60	15	20	234	40	1		1	2	2	1				1	1		690	32 95	39.39
33505	Repair artery w/tunnel	5	6	90	1	40	12	20	200	40	1		9		1	1				1			646	26.80	36.00
33510	CABG, vein, single	7,775	6	90	4	60	15	20	154	40	1		1	2	3	1			1		1		643	28.96	31 75
33511	CABG, vein, two	8,165	6	90	4	60	15	20	186	40	1		1	2	3	1			1		1		675	29 96	35 22
33512	CABG, vein, three	8,168	6	90	4	60	15	20	213	40	1		1	2	4	1			1		1		743	31 75	40 26
33513	CABG, vein, four	3,873	6	90	4	60	15	20	231	40	1		1	2	4	1			1		1		761	31 95	41.65
33514	CABG, vein, five	1,103	6	90	4	60	15	20	248	40	1		1	2	4	1			1		1		778	32.70	44.36
33516	Cabg, vein, six or more	233	6	90	4	60	15	20	264	40	1		1	2	4	1			1		1		794	34.95	46 04
33517	CABG, artery-vein, single	20,588	6	ZZZ	1				23		0 2				0								47 9	2 57	3.36

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33518	CABG, artery-vein, two	46,283	6	ZZZ	1				50		0 36				1								100 6	4.84	7.41
33519	CABG, artery-vein, three	36,938	6	ZZZ	1				70		0 4				1								126 4	7 11	9.91
33521	CABG, artery-vein, four	12,106	6	ZZZ	1				88		0 38				1								144.3	9 39	12 01
33522	CABG, artery-vein, five	2,129	6	ZZZ	1				102		0 32				1								159.5	11 65	13 53
33523	Cabg, art-vein, six or more	399	6	ZZZ	1				110		0 4				1								176.2	13 93	15 39
33530	Coronary artery, bypass/reop	15,685	6	ZZZ	1				70		0 26				0								104.4	5 85	9 78
33533	CABG, arterial, single	113,651	6	90	4	60	15	20	151	40	1		1	1	3	1			1		1		610	29.96	30.85
33534	CABG, arterial, two	11,647	6	90	4	60	15	20	193	40	1		1	1	3	1			1		1		652	32.15	36.98
33535	CABG, arterial, three	2,937	6	90	4	60	15	20	231	40	1		1	1	3	1			1		1		690	34.45	41.85
33536	Cabg, arterial, four or more	1,119	6	90	4	60	15	20	259	40	1		1	1	3	1			1		1		718	37.44	45.53
33542	Removal of heart lesion	1,167	6	90	4	60	15	20	207	40	2		1	2	3	1				1	1		767	28.81	44.20
33545	Repair of heart damage	159	6	90	4	60	15	20	236	40	2	1	1	1	4		1			1	1		848	36.72	52.49
33641	Repair heart septum defect	2,330	6	90	4	60	15	20	164	40	1		1	1	1	1					1		526	21.36	27.71
33665	Repair of heart defects	2	6	90	1	60	15	15	200	60	1		1	1	1	1					1		577	28.56	32.98
33684	Repair heart septum defect	3	6	90	1	63	15	15	200	60	1		1	1	1	1					1		580	29.61	32 50
33688	Repair heart septum defect		6	90	4	60	15	15	235	40	1		1	1	1	1					1		592	30.57	32 88
33771	Repair great vessels defect	1	6	90	4	60	15	15	260	60	1		4	1	1	1				1			679	34 60	38.50
33779	Repair great vessels defect		6	90	4	60	15	15	280	40	1		4	1	1	1					1		694	36.16	41 00
33781	Repair great vessels defect	1	6	90	4	60	12	15	280	40	1		6	2		1				1			703	36.40	41 00
33860	Ascending aortic graft	2,862	6	90	4	45	15	20	305	40	2		1	2	3	1				1	1		850	37.94	55 45
33863	Ascending aortic graft	1,815	6	90	4	60	15	20	287	40	2		1	2	3	1					1		824	44 93	55.10
33877	Thoracoabdominal graft	920	7	90	1	50	45	15	324	60	3		1	2	3		1			2	1		1014	42 54	64.04
33945	Transplantation of heart	520	6	90	4	167	15	90	325	85	3	1	1	6	5		1			3	2	1	1556	42.04	80.84
34001	Removal of artery clot	208	7	90	1	30	15	15	90	30				3		1				2			352	12 89	16.25
34201	Removal of artery clot	7,971	7	90	4	30	15	15	128	30			2	2		1				2			398	10.01	18.31
34471	Removal of vein clot	51	7	90	1	30	15	15	180	20			3	1		1			2	1			436	10 16	20.00
35081	Repair defect of artery	7,765	7	90	4	60	15	15	210	30	1		2	3		1			1	1	1		633	27.97	31 00
35102	Repair defect of artery	5,321	7	90	4	60	15	15	265	30	1		2	3		1			1	1	1		688	30.71	36 28
35216	Repair blood vessel lesion	286	7	90	4	30	15	15	180	60	1		3	3		1		1		1	1		614	18.72	34 00
35506	Artery bypass graft	83	7	90	1	30	15	15	165	28			1	1	1	1				2			425	19.64	23.75
35508	Artery bypass graft	20	7	90	1	30	15	15	170	30			1	1		1				2			391	18.62	25.00
35515	Artery bypass graft	6	7	90	1	30	15	15	180	30			1	1		1				2			401	18 62	25.00
35516	Artery bypass graft	35	7	90	1	30	15	15	180	20			2	1		1				2			410	16 30	23.00
35556	Artery bypass graft	6,905	7	90	4	30	25	15	251	30			2	1	1	1			1	2			557	21 73	27.25
35566	Artery bypass graft	6,573	7	90	4	30	25	15	306	30			3	2	1		1		1	2			670	26 88	32.00
35583	Vein bypass graft	3,004	7	90	4	30	25	15	253	30			2	1	1	1			1	2			559	22 34	26.00
35585	Vein bypass graft	4,203	7	90	4	30	25	15	305	30			3	2	1		1		1	2			669	28 35	32.00
35606	Artery bypass graft	755	7	90	1	30	15	15	145	30				1	1	1				2			388	18.68	21.00
35616	Artery bypass graft	72	7	90	4	30	15	15	140	30			1	1		1			1	1			353	15 68	21 00
35820	Explore chest vessels	7,333	6	90	4	30	10	5	136	40	1		1	2	6	1					1		683	12 86	32 24
38100	Removal of spleen, total	4,133	7	90	4	30	15	15	120	30			3	1	1	1			1	1			412	14 48	18.00
38101	Removal of spleen, partial	45	7	90	1	30	15	15	120	30			3	1	1	1			1	1			412	15.29	18.00
38115	Repair of ruptured spleen	245	7	90	1	30	15	15	120	40			3	2	1	1			1	1			452	15.80	20.00
38700	Removal of lymph nodes, neck	918	8	90	1	30	15	15	90	30			1			1 0			1	2			296	8.23	12.00
38720	Removal of lymph nodes, neck	960	8	90	1	45	15	15	150	30			2	1		1 0				3	1		466	13 59	20.00
38724	Removal of lymph nodes, neck	4,620	8	90	1	45	15	15	180	30			2	1		1 0				3	1		496	14 52	22.00
39220	Removal chest lesion	522	6	90	4	60	15	20	124	40			1	2		1			1	1			412	17 39	18.40

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39400	Visualization of chest	14,114	6	10	1	35	15	20	45	25			1			1				1			218	5.60	7.61
41100	Biopsy of tongue	6,785	8	10	2	10	10	5	15	10								1					65	1.63	1.63
41120	Partial removal of tongue	1,537	8	90	2	30	15	15	60	30						05				3	1		275	9 76	9 76
41130	Partial removal of tongue	267	8	90	1	45	15	20	90	30			3			10				3	1		400	11.13	14 00
41135	Tongue and neck surgery	336	8	90	1	60	15	20	210	30			2	2	1	10			1	4	1		655	23 06	27 00
41140	Removal of tongue	23	8	90	2	60	15	20	155	40			3	3	1	10			1	3	2		674	25.46	25 46
41145	Tongue removal, neck surgery	51	8	90	1	60	15	20	300	40			5	3	1	10			1	3	2		857	30.01	34.00
41150	Tongue, mouth, jaw surgery	249	8	90	1	60	15	20	180	40			3	2	1	10			1	3	2		669	23.01	26 50
41153	Tongue, mouth, neck surgery	163	8	90	1	60	15	20	270	40			3	3	1	10			1	4	1		774	23 73	34 00
41155	Tongue, jaw, & neck surgery	548	8	90	1	60	15	20	320	40			4	3	2	10			1	3	2		899	27 68	40 00
42120	Remove palate/lesion	590	8	90	1	30	15	15	80	30			1			10			2	2			301	6.16	11 00
42842	Extensive surgery of throat	265	8	90	1	30	15	15	80	30			1			10			1	2	1		324	8.75	11.00
42844	Extensive surgery of throat	85	8	90	1	45	15	15	120	30			2	1		10			1	2	1		428	14.29	16.10
42845	Extensive surgery of throat	54	8	90	1	60	15	20	240	40			4	3	2	10			1	2	1		758	24.25	32.00
42890	Partial removal of pharynx	227	8	90	1	45	15	20	120	30			3	2		10			1	2	1		482	12.92	17.00
42892	Revision of pharyngeal walls	133	8	90	1	45	15	20	170	35			3	2	1	10			1	3	1		601	15.81	23 09
42894	Revision of pharyngeal walls	100	8	90	1	60	15	20	240	40			3	4	1	10			1	4	1		774	22 85	30 00
43108	Removal of esophagus	27	6	90	4	60	15	20	461	40	1		1	6	5		1		1	2	1		1207	34.14	76 55
43113	Removal of esophagus	11	6	90	4	60	15	20	391	40	2		1	6	5		1		1	2	1		1200	35 22	73 23
43116	Partial removal of esophagus	12	6	90	4	60	15	20	561	40	1		1	6	4		1		1	2	1		1266	31 17	87 16
43118	Partial removal of esophagus	20	6	90	4	60	15	20	327	40	1		1	5	5		1		1	2	1		1043	33 15	61 08
43121	Partial removal of esophagus	60	6	90	4	60	15	20	240	40	1		1	3	4		1		1	2	1		855	29 15	46 59
43123	Partial removal of esophagus	26	6	90	4	60	15	20	442	40	1		1	8	5		1		1	2	1		1248	33 15	76 14
43124	Removal of esophagus	50	6	90	4	60	15	20	243	40	3		1	7	6		1		1	3	1		1209	27 28	60.61
43135	Removal of esophagus pouch	132	6	90	4	60	15	20	164	40			1	3	1	1			1	1			523	16.08	24.20
43235	Uppr gi endoscopy, diagnosis	510,944	4	0	2	18	5	5	20	15													63	2 39	2.39
43246	Place gastrostomy tube	136,643	4	0	2	35	8	5	38	20													106	4.32	4.32
43620	Removal of stomach	180	7	90	1	30	15	15	200	30	1		3	3	1	1			1	2			638	29.99	31.00
43621	Removal of stomach	767	7	90	4	30	15	15	240	30	1		3	3	2	1			1	2			719	30.68	36 00
43622	Removal of stomach	147	7	90	4	30	15	15	240	30	1		3	3	2	1			1	2			719	32.48	36 50
43632	Removal of stomach, partial	2,910	7	90	4	30	15	15	225	30			4	3	2	1			1	2			660	22.56	32.00
43633	Removal of stomach, partial	1,381	7	90	4	30	15	15	240	30			4	3	2	1			1	2			675	23 07	30 00
43634	Removal of stomach, partial	32	7	90	1	30	15	15	240	30			4	3	2	1			1	2			675	25 08	33 50
43750	Place gastrostomy tube	32,754	4	10	2	16	10	10	30	15			1						1				115	4 48	4 48
43820	Fusion of stomach and bowel	2,938	7	90	4	30	15	15	120	30			3	3	1	1			1	2			495	15.35	20.00
43840	Repair of stomach lesion	5,556	7	90	4	30	15	15	90	30	1		4	2	1	1			1	2			517	15.54	20.00
44120	Removal of small intestine	30,806	7	90	4	30	15	15	134	30			4	3	2	1			1	1			546	16.97	20 11
44130	Bowel to bowel fusion	2,707	7	90	4	30	15	15	131	30			5	1	1	1			1	2			484	14 47	20.87
44140	Partial removal of colon	48,464	7	90	2	30	15	15	150	30			5	1		1			1	2			462	20 97	20 97
44143	Partial removal of colon	17,331	7	90	4	30	15	15	150	30			3	2	2	1			1	1	1		551	22.96	25 00
44150	Removal of colon	5,469	7	90	4	30	15	15	180	30			3	3	1	1			2	1	1		585	23.91	27.50
44151	Removal of colon/ileostomy	99	7	90	4	30	15	15	240	30			5	3	1	1			2	1	1		683	26 84	32.00
44155	Removal of colon/ileostomy	934	7	90	4	30	15	15	240	30			5	3	1	1			2	1	1		683	27 82	31 50
44156	Removal of colon/ileostomy	27	7	90	1	30	15	15	300	30			5	3	1	1			2	1	1		743	30 74	34 50
44602	Suture, small intestine	4,803	7	90	4	30	15	15	90	30	1		3	3	1	1			1	1			505	16 01	22 00
44603	Suture, small intestine	1,687	7	90	1	30	15	15	120	30	1		4	3	1	1			1	2			577	18 63	25 00
45020	Drainage of rectal abscess	637	7	90	1	30	15	15	45	30			1			1			1	2			251	4 71	7 75

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45300	Proctosigmoidoscopy dx	57,539	7	0	4	10	5	1	10	10													36	0.38	0 91
45303	Proctosigmoidoscopy dilate	504	7	0	4	20	10	5	20	30													85	0.44	2.22
45305	Proctosigmoidoscopy w/bx	2,219	7	0	4	20	10	5	15	30													80	1 01	2.01
45307	Proctosigmoidoscopy fb	151	7	0	4	20	10	5	20	30													85	0 94	2.22
45308	Proctosigmoidoscopy removal	280	7	0	4	20	10	5	15	30													80	0 83	2.01
45309	Proctosigmoidoscopy removal	229	7	0	4	20	10	5	20	30													85	2 01	2.22
45315	Proctosigmoidoscopy removal	110	7	0	4	20	10	5	20	30													85	1 40	2 22
45317	Proctosigmoidoscopy bleed	930	7	0	4	10	5	1	15	10													41	1.50	1.08
45320	Proctosigmoidoscopy ablate	207	7	0	4	20	10	5	25	30													90	1 58	2.43
45321	Proctosigmoidoscopy volvul	271	7	0	4	20	10	5	30	30													95	1 17	2.76
45327	Proctosigmoidoscopy w/stent	22	7	0	4	20	10	5	45	30													110	1.65	3 63
45330	Diagnostic sigmoidoscopy	122,925	4	0	2	7			17	8													32	0.96	0 96
45378	Diagnostic colonoscopy	1,143,087	4	0	2	20	5	5	30	15													75	3 69	3 69
46040	Incision of rectal abscess	5,767	7	90	2	30	15	15	30	20						05			2	1			181	4.95	4.95
46045	Incision of rectal abscess	338	7	90	1	30	15	15	30	30						1			1	1			194	4 31	5.50
46060	Incision of rectal abscess	1,104	7	90	2	30	15	15	40	20						05			1	2			199	5.68	5.68
46270	Removal of anal fistula	1,691	7	90	1	30	15	15	15	20						05			2	1			166	3.71	4.50
46275	Removal of anal fistula	1,218	7	90	1	30	15	15	30	20						05			2	1			181	4.55	5 00
46280	Removal of anal fistula	1,519	7	90	2	30	15	15	45	20						05			2	1			196	5.97	5.97
46285	Removal of anal fistula	130	7	90	1	30	15	15	30	20						05			2	1			181	4.08	5 00
46600	Diagnostic anoscopy	95,217	7	0	4	5	2	1	7	5													20	0.50	0 49
46604	Anoscopy and dilation	1,511	7	0	4	10	5	1	15	10													41	1.31	1.08
46606	Anoscopy and biopsy	1,713	7	0	4	20	10	5	10	30													75	0 81	1.76
46608	Anoscopy, remove for body	110	7	0	4	20	10	5	15	30													80	1 51	1 95
46610	Anoscopy, remove lesion	284	7	0	4	20	10	5	15	30													80	1 32	1 95
46611	Anoscopy	176	7	0	4	10	5	1	15	10													41	1.81	1 08
46612	Anoscopy, remove lesions	106	7	0	4	20	10	5	20	30													85	2 34	2.14
46614	Anoscopy, control bleeding	1,737	7	0	4	5	5	1	15	15													41	2 01	1 08
46615	Anoscopy	322	7	0	4	10	5	1	18	10													44	2.68	1.18
47562	Laparoscopic cholecystectomy	119,297	7	90	2	30	15	15	80	25						05			1	2			244	11.07	11.07
47600	Removal of gallbladder	29,510	7	90	4	30	15	15	115	30			1	1	1	1			1	2			392	13.56	15.88
47760	Fuse bile ducts and bowel	819	7	90	4	45	15	15	195	45	1		3	2	2	1				2	1		697	25 81	34.75
47765	Fuse liver ducts & bowel	43	7	90	1	45	15	15	290	53	1		4	2	2	1				2	1		819	24 84	48.50
47780	Fuse bile ducts and bowel	1,173	7	90	4	45	15	15	240	40	1		3	2	2	1				2	1		737	26.46	38 75
47785	Fuse bile ducts and bowel	306	7	90	4	45	15	15	360	40	1		4	2	2	1				2	1		876	31.13	52 50
49002	Reopening of abdomen	4,599	7	90	4	30	15	15	75	30			3	2	1	1			1	1			397	10 47	15.75
49010	Exploration behind abdomen	1,646	7	90	4	30	15	15	90	30			3	1		1			1	1			341	12 26	15.00
49505	Prp i/hern init reduc >5 yr	107,403	7	90	2	20	15	15	70	20						05			1	1			196	7.59	7 59
50590	Fragmenting of kidney stone	52,828	3	90	2	35	15	13	60	30						05			1	2			232	9.08	9.08
51720	Treatment of bladder lesion	208,892	3	0	4	20	2	5	12	10													49	1 96	1 50
51798	Us urine capacity measure	1,174,387	3	XXX	1	5			4														9	0 00	0.38
52000	Cystoscopy	952,641	3	0	4	10	2	5	15	10													42	2.01	2.23
52204	Cystoscopy	39,733	3	0	4	10	2	5	25	12													54	2.37	2 59
52601	Prostatectomy (TURP)	70,777	3	90	4	35	10	15	75	40			2	1		1			1	2			340	12.35	14 00
55700	Biopsy of prostate	233,082	3	0	4	20	5	5	15	20													65	1.57	2 58
57160	Insert pessary/other device	111,204	3	0	2	10	5	5	15	5													40	0.89	0 89
57240	Repair bladder & vagina	14,024	3	90	4	45	5	10	60	30			2	1		1			1	1			292	6 06	10 56

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57250	Repair rectum & vagina	9,539	3	90	4	45	5	10	60	30			2	1		1		1	1				292	5.52	10.56
57260	Repair of vagina	17,038	3	90	4	45	5	10	90	30			2	1		1		1	1				322	8.26	13.50
57265	Extensive repair of vagina	6,676	3	90	4	45	5	10	120	30			2	1		1		1	1				352	11.32	15 00
57288	Repair bladder defect	38,242	3	90	2	35	10	15	60	40			1	1		1		1	2				306	13.00	13 00
57500	Biopsy of cervix	9,266	3	0	4	7	1	1	15	5													29	0.97	1.20
58120	Dilation and curettage	19,325	3	10	2	20	5	10	25	27						0 5			1				128	3.27	3.27
58150	Total hysterectomy	24,214	3	90	4	45	5	10	120	30			3	1		1			2				379	15.22	15.98
58720	Removal of ovary/tube(s)	8,593	3	90	2	37	5	10	90	30			1	1		1		1	1				295	11.34	11.34
60600	Remove carotid body lesion	119	7	90	1	45	15	15	180	30			1	1		1			2				416	17.90	24 00
60605	Remove carotid body lesion	32	7	90	1	45	15	15	240	36				1	1	1			2				504	20.21	30 50
61154	Pierce skull & remove clot	8,547	3	90	2	60	15	15	60	30			4	2		1			3				421	14.97	14 97
61312	Open skull for drainage	9,350	3	90	1	60	15	15	150	30			6	4	1	1			2				627	24.53	27 00
61537	Removal of brain tissue	115	3	90	1	60	20	20	265	45			4	1		1			2				598	24.96	35 00
61538	Removal of brain tissue	109	3	90	1	60	20	20	330	45			4	1		1			2				663	26.77	38 00
61697	Brain aneurysm repr, complx	781	3	90	4	60	30	15	300	50			5	6	5	1			2	1			1055	50 44	57 31
61698	Brain aneurysm repr, complx	60	3	90	4	60	40	15	360	50			5	6	4	1			2	1			1084	48 34	64 03
61700	Brain aneurysm repr, simple	1,181	3	90	4	60	30	15	240	40			5	3	4	1			2	1			854	50 44	46.01
61702	Inner skull vessel surgery	44	3	90	4	60	40	15	280	50			5	5	5	1			2	1			1015	48 34	54.28
62270	Spinal Fluid Tap, diagnostic	76,191	4	0	4	7			20	5													32	1.13	1.37
63047	Removal of spinal lamina	75,647	3	90	3	60	20	15	90	30				1		1			3				350	14 59	14.08
63048	Remove spinal lamina add-on	118,656	3	ZZZ	4				45														45	3 26	3.55
63075	Neck spine disk surgery	19,930	3	90	3	60	20	15	90	30				1		1		1	2				342	19 38	18.58
64702	Revise finger/toe nerve	768	2	90	4	20	15	10	50	20						0 5		2	2				209	4 22	5.52
64721	Carpal tunnel surgery	114,443	2	90	2	20	15	10	25	20						0 5		1	2				169	4 28	4.28
65426	Removal of eye lesion	4,706	8	90	4	5	5	10	47 5	12						0 5		4					157 5	5.24	5.85
65850	Incision of eye	338	8	90	4	15	10	12.5	60	17.5						1 0		5					226	10.50	11.14
66761	Revision of iris	85,708	8	90	2	10	5	1	10	10									3				105	4.06	4.06
66821	After cataract laser surgery	675,728	8	90	4	15			11	10									2				82	2 35	2.78
66984	Cataract surg w/iol, 1 stage	1,802,958	8	90	4	10	5	10	30	10						0 5		2	2				159	10 21	9 78
67221	Ocular photodynamic ther	126,894	8	0	4	10	0	0	15	5													30	4 00	3 45
67414	Explr/decompress eye socket	318	8	90	1	15	10	15	120	30				1		1 0		1	1	1			332	11.11	16 82
67445	Explr/decompress eye socket	222	8	90	1	15	15	15	120	30				1		1 0		1	1	1			337	14.40	18.00
67500	Inject/treat eye socket	16,121	8	0	1	5	5	5	5	5													25	0 79	1.44
67505	Inject/treat eye socket	1,210	8	0	1	10	5	5	10	5													35	0.82	1.27
67515	Inject/treat eye socket	35,076	8	0	1	6	5	0	5	5													21	0.61	1.40
67820	Revise eyelashes	285,124	8	0	3	5	2	1	5	2													15	0.89	0 71
67840	Remove eyelid lesion	49,843	8	10	2	5	5	5	15	10								1					55	2.04	2.04
67904	Repair eyelid defect	56,300	8	90	1	10	10	15	45	15						0 5		3	1				181	6 25	7.50
67911	Revise eyelid defect	2,790	8	90	1	10	10	15	50	15						0 5		4					178	5 26	7.30
67966	Revision of eyelid	5,926	8	90	1	10	10	15	60	15						0 5		3	1				196	6 56	8.50
68840	Explore/irrigate tear ducts	37,656	8	10	2	5	3	0	10	5								1					38	1 25	1.25
69210	Remove impacted ear wax	1,322,628	8	0	2	5	2	0	10	2													19	0 61	0.75
70355	Panoramic x-ray of jaws	28,678	4	XXX	2				5	1													6	0.20	0.20
71010	Chest x-ray	18,282,814	4	XXX	2	1			3	1													5	0.18	0.18
71020	Chest x-ray	15,676,163	4	XXX	2	1			3	1													5	0 22	0.22
71260	Ct thorax w/dye	1,971,811	4	XXX	2	3			15	5													23	1 24	1.24
72192	Ct pelvis w/o dye	1,222,624	4	XXX	2	3			10	5													18	1 09	1.09

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
72193	Ct pelvis w/dye	2,308,971	4	XXX	2	3			10	5													18	1.16	1.16
73100	X-ray exam of wrist	458,439	4	XXX	2	1			3	1													5	0 16	0 16
73110	X-ray exam of wrist	753,523	4	XXX	2	1			3	1													5	0.17	0.17
73120	X-ray exam of hand	296,490	4	XXX	2	1			3	1													5	0 16	0 16
73130	X-ray exam of hand	755,783	4	XXX	2	1			3	1													5	0 17	0 17
73140	X-ray exam of finger(s)	310,708	4	XXX	2	1			2	1													4	0 13	0 13
74000	X-ray exam of abdomen	1,838,163	4	XXX	2	1			3	1													5	0 18	0 18
74020	X-ray exam of abdomen	994,189	4	XXX	2	1			3	1													5	0 27	0.27
74022	X-ray exam series, abdomen	1,089,991	4	XXX	2	1			5	1													7	0 32	0.32
74150	Ct abdomen w/o dye	1,315,665	4	XXX	2	3			12	5													20	1.19	1.19
74160	Ct abdomen w/dye	2,145,140	4	XXX	2	3			15	5													23	1.27	1.27
76075	Dxa bone density, axial	2,426,361	4	XXX	4	1			4	1													6	0.30	0.20
76519	Echo exam of eye	1,322,402	8	XXX	2	5	7	0	5	0													17	0.54	0.54
76700	Us exam, abdom, complete	1,329,410	4	XXX	2	3			10	4													17	0.81	0 81
76830	Transvaginal us, non-ob	325,124	4	XXX	2	3			12	5													20	0.69	0.69
77263	Radiation therapy planning	276,554	4	XXX	2				75														75	3.14	3.14
77280	Set radiation therapy field	240,934	4	XXX	2				23														23	0 70	0.70
77290	Set radiation therapy field	348,188	4	XXX	2				70														70	1.56	1.56
77300	Radiation therapy dose plan	1,282,101	4	XXX	2				15														15	0.62	0.62
77315	Teletx isodose plan complex	152,581	4	XXX	2				45														45	1.56	1.56
77331	Special radiation dosimetry	321,893	4	XXX	2				30														30	0.87	0 87
77334	Radiation treatment aid(s)	1,087,833	4	XXX	2				35														35	1.24	1 24
77470	Special radiation treatment	139,703	4	XXX	2				55														55	2.09	2.09
78306	Bone imaging, whole body	722,160	4	XXX	2	5			8	5													18	0.86	0.86
78315	Bone imaging, 3 phase	139,583	4	XXX	2	5			10	5													20	1.02	1 02
78465	Heart image (3d), multiple	2,930,407	4	XXX	2	5			20	5													30	1.46	1.46
78478	Heart wall motion add-on	2,765,566	4	XXX	4				10	1													11	0 62	0.50
78480	Heart function add-on	2,766,786	4	XXX	4				5	1													6	0 62	0 30
88309	Tissue exam by pathologist	200,175	4	XXX	4				90														90	2 28	2.80
88321	Microslide consultation	155,079	4	XXX	4				50														50	1 30	1.63
88323	Microslide consultation	34,714	4	XXX	4				56														56	1.35	1 83
88325	Comprehensive review of data	21,487	4	XXX	4				80														80	2 22	2.50
92083	Visual field examination(s)	2,434,073	8	XXX	2	3	0	0	10	0													13	0.50	0.50
92226	Special eye exam, subsequent	1,965,033	8	XXX	2	5	0	0	10	5													20	0.33	0.33
92235	Eye exam with photos	1,560,890	8	XXX	2				28														28	0.81	0 81
92250	Eye exam with photos	1,697,307	8	XXX	2	0	0	0	9	5													14	0.44	0.44
93010	Electrocardiogram report	19,204,537	4	XXX	2				5	2													7	0 17	0.17
93015	Cardiovascular stress test	2,252,974	4	XXX	2	2			15	4													21	0 75	0 75
93018	Cardiovascular stress test	1,503,471	4	XXX	2	2			5	5													12	0.30	0 30
94010	Breathing capacity test	1,237,293	4	XXX	2				5	2													7	0.17	0 17
95144	Antigen therapy services	303,805	4	0	2				3														3	0.06	0 06
95165	Antigen therapy services	6,017,763	4	0	2				3														3	0.06	0 06
95816	Eeg, awake and drowsy	228,893	4	XXX	2	5			15	10													30	1.08	1 08
95819	Eeg, awake and asleep	389,584	4	XXX	2	5			20	10													35	1 08	1.08
95861	Muscle test, 2 limbs	295,258	4	XXX	2	15			25	10													50	1.54	1.54
95872	Muscle test, one fiber	909	4	XXX	1	15			60	20													95	1 50	3.00
95900	Motor nerve conduction test	1,365,558	4	XXX	2	4			6	4													14	0.42	0.42

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99241	99242	99243	99244	99245	Total Time	2005 work RVU	RUC Rec Work RVU
95904	Sense nerve conduction test	2,749,528	4	XXX	2	4			5	3													12	0.34	0 34
95925	Somatosensory testing	44,977	4	XXX	2	6.5			15	10													31 5	0 54	0.54
95926	Somatosensory testing	68,412	4	XXX	2	6 5			15	10													31.5	0 54	0.54
95927	Somatosensory testing	2,953	4	XXX	2	6 5			15	10													31.5	0 54	0.54
95953	EEG monitoring/computer	9,284	4	XXX	4	10			60	15													85	3 08	3.30
99201	Office/outpatient visit, new	465,665	5	XXX	2	3			10	5													18	0 45	0.45
99202	Office/outpatient visit, new	2,742,495	5	XXX	2	5			15	5													25	0 88	0.88
99203	Office/outpatient visit, new	5,007,937	5	XXX	2	5			25	10													40	1.34	1 34
99204	Office/outpatient visit, new	3,201,161	5	XXX	4	5			40	12													57	2 00	2 30
99205	Office/outpatient visit, new	1,097,515	5	XXX	4	10			50	15													75	2 67	3 00
99211	Office/outpatient visit, est	10,445,542	5	XXX	2	0			5	3													8	0 17	0 17
99212	Office/outpatient visit, est	26,139,270	5	XXX	2	3			10	5													18	0 45	0 45
99221	Initial hospital care	518,754	5	XXX	4	10			30	13													53	1.28	1 88
99222	Initial hospital care	3,486,006	5	XXX	4	15			40	20													75	2.14	2 56
99223	Initial hospital care	5,721,509	5	XXX	4	20			55	25													100	2.99	3 78
99231	Subsequent hospital care	20,534,153	5	XXX	4	5			15	5													25	0 64	0 76
99232	Subsequent hospital care	50,336,836	5	XXX	4	10			20	10													40	1 06	1.30
99233	Subsequent hospital care	17,225,862	5	XXX	4	10			25	15													50	1 51	2 00
99238	Hospital discharge day	6,416,301	5	XXX	2	9			20	10													39	1 28	1.28
99239	Hospital discharge day	2,279,088	5	XXX	4	10			30	15													55	1.75	1.90
99241	Office consultation	456,792	5	XXX	2	5			15	5													25	0.64	0.64
99242	Office consultation	1,767,974	5	XXX	4	5			25	10													40	1 29	1 34
99243	Office consultation	4,897,411	5	XXX	4	10			35	10													55	1.72	1 88
99244	Office consultation	5,512,793	5	XXX	4	10			45	15													70	2.58	3 02
99245	Office consultation	2,122,524	5	XXX	4	15			60	20													95	3.42	3.77
99251	Initial inpatient consult	366,384	5	XXX	4	5			20	5													30	0.66	1 00
99252	Initial inpatient consult	1,157,331	5	XXX	4	5			35	10													50	1.32	1.50
99253	Initial inpatient consult	3,391,552	5	XXX	4	10			40	15													65	1.82	2.27
99254	Initial inpatient consult	5,626,795	5	XXX	4	15			50	20													85	2.64	3.29
99255	Initial inpatient consult	2,817,081	5	XXX	4	20			60	25													105	3.64	4.00
99281	Emergency dept visit	178,635	5	XXX	4	2			7	4													13	0.33	0.45
99282	Emergency dept visit	1,095,199	5	XXX	4	3			10	5													18	0.55	0 88
99283	Emergency dept visit	5,159,423	5	XXX	4	5			18	7													30	1.24	1 34
99284	Emergency dept visit	5,520,136	5	XXX	4	5			25	10													40	1 95	2.56
99285	Emergency dept visit	6,534,826	5	XXX	4	8			40	15													63	3 06	3.80
99291	Critical care, first hour	2,960,371	5	XXX	4	15			40	20													75	3.99	4 29
99292	Critical care, addl 30 min	340,790	5	ZZZ	4				30														30	2.00	2 15

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Recommendations - Dermatology and Plastic Surgery

The following members of Workgroup met on August 25th to review work relative value recommendations for craniofacial, mohs surgery, excision of lesions, other plastic surgery, and other dermatology services: Barbara Levy, MD (Chairwoman), James Anthony, MD, Mary Foto, OTR, Charles Koopmann, Jr, MD, J. Leonard Lichtenfeld, MD, and Samuel D. Smith, MD. The RUC reviewed and approved these recommendations at their September 29-October 2, 2005 meeing.

Hidradenitis

The American Society of Plastic Surgeons (ASPS) submitted the hidradenitis services (CPT codes 11450, 11451, 11462, 11463, 11470, and 11471) as undervalued as the specialty argued that incorrect assumptions made in previous Harvard evaluation. The specialty stated that the entire family is undervalued as the post-operative time is low. The specialty conducted a survey, but received a very low response rate. Therefore, ASPS withdrew this family of codes from the Five-Year Review.

Craniofacial Surgery

ASPS also submitted comments to CMS to review the following ten craniofacial surgery codes: 21145, 21146, 21147, 21365, 21366, 21395, 21432, 21433, 21436, and 21470. The specialty argued that there are anomalous relationships between these codes and other codes. The specialty conducted a survey for each of these ten codes, but received a very low response rate for most of these services. Therefore, ASPS withdrew six of these codes (21365, 21366, 21432, 21433, 21436, and 21470) from the Five-Year Review.

The specialty did present survey data for codes 21145, 21146, 21147, and 21395 to the RUC. The specialty argued that there is compelling evidence that these codes had been valued based on an incorrect assumption regarding the value of the bone graft portion of the service. The specialty society and the RUC had agreed in April 1995 that the appropriate increment of work was 2.00. The basis for this decision is unclear. The committee agrees that the appropriate increment of work for the bone graft should be 50% of 20902 *Bone graft, any donor area; major or large* (7.54 * 50% = 3.77). The RUC recommends that this appropriate increment of 3.77 be utilized and added to the base code for each of these services.

Other Plastic Surgery Services

ASPS submitted five other miscellaneous services to the Five-Year Review, including: 11960, 15831, 19361, 43496, and 49906. The rationale for submission of these codes was largely based on a statement that incorrect assumptions were made in previous valuation or there had been changes in the service over the past ten years. ASPS surveyed each of these service, but was unable to obtain an adequate response rate and withdrew codes 11960, 19361, 43496, and 49906. The RUC agreed with the specialty that a CPT proposal should be completed for the services currently described in CPT code 15831 to capture the new population of patients presenting for excision of excessive skin and subcutaneous tissue in the lower abdomen, because of the tremendous increase in bariatric procedures for massive weight loss.

CMS submitted the following other plastic surgery services as the services had never been reviewed by the RUC: 15100, 15240, 15734. The specialty surveyed these three codes and the RUC was convinced that the survey data validated the current valuation of these service. 15732 was submitted by CMS because the service had been valued as an inpatient service and it is now performed as an outpatient service. After survey and discussion, it became apparent that CPT code 15732 describes two disparate procedures, allowing both superficial repairs and repair of more serious cancer defects to be reported with 15732. The plastic surgeons will coordinate with otolaryngology and ophthalmology to develop a coding proposal to specifically identify these services in new CPT codes.

Other Dermatology

The AAD and DUSA submitted CPT code 96567 *Photodynamic treatment, skin* and commented that the original vignette failed to recognize the degree of pain associated with this treatment and the consequent need for physician involvement. The RUC had reviewed this service in April 1991 and rejected the specialties recommendation at that time that the service required physician involvement. Dermatology has re-surveyed the code and presented the information to the RUC. After extensive discussion with the RUC regarding the potential need for further CPT revisions, the specialty decided to instead withdraw the code from the Five-Year Review.

CMS submitted several other integumentary services for review, including the following seven codes because they had never been reviewed by the RUC: 11100, 12052, 13121, 14040, 14060, 17262, and 17281. The specialty surveyed these seven codes and the RUC was convinced that the survey data validated the current valuation of these service.

CMS also CPT code 17003 *Destroy lesions, 2-14, each*, because advances in technology have likely resulted in a modification to the physician work required to accomplish the procedure. At the meeting, CMS staff noted that the new Medicare coverage policies related to actinic keratoses (AK) has increased the reporting of this service to describe cryosurgical destruction of AK. The RUC reviewed previous and current survey data and agreed that the application of cryosurgery to each lesion requires no more than two minutes of physician time. Therefore the current work relative value overestimates this time-limited, low intensity service. The RUC discusses its specific recommendation and rationale for this code in the attached document.

Mohs Surgery

CMS referred the Mohs surgery codes 17304 and 17305 to the Five-Year Review as this family of services have never been surveyed and reviewed by the RUC. The specialty conducted surveys to collect data for these two codes. The Workgroup had an extensive discussion regarding the various steps in the performance of this procedure and the physician involvement and time for each of these steps/activities. The Workgroup reviewed the history of these services and discussed the following February 2003 RUC action:

> *The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion and anatomical site, rather than the number of specimens. The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated.*

To date, there have been no attempts to discuss the Mohs surgery section with the CPT Editorial Panel and efforts to reach consensus with the Mohs surgery community on a coding proposal has been unsuccessful. RUC agreed with the prior conclusions of the RUC and is unable to validate the current work relative values absent a fundamental coding change within this section of CPT.

Excision of Lesions

CMS submitted all of the excision of lesion codes (benign: 11400-11446, malignant: 11600-11646), noting that these services have never been surveyed and reviewed by the RUC. The RUC first reviewed the history of the coding related to these services. In November 2001, the CPT Editorial Panel modified the nomenclature, changing the measurement of the lesion to include the lesion plus the margin required for complete excision. At the April 2002 RUC meeting, the RUC agreed with dermatology, family medicine, general surgery, and plastic surgery to determine new work relative values for these services using a mathematical model that 1) estimated 30% of benign lesions and 50% of malignant lesions would be reported with the next higher code as a result of the change in descriptors; 2) maintained the relative ratio between codes within each family; and 3) maintained budget neutrality within each family. CMS agreed with the RUC recommendations and the new codes and work relative values were implemented on January 1, 2003.

However, in *Proposed Rule* for the 2004 MFS, CMS indicated that they believe the work relative values for the excision of benign and malignant lesions of the same size should be equivalent. CMS proposed to utilize a weighted average approach for each code pair to establish new equivalent work relative value units. The RUC and several specialties commented in opposition to this proposal and requested CMS to seek additional input on this issue. In the *Final Rule* for the 2004 MFS, CMS agreed to postpone consideration of this issue until the specialties had opportunity to survey these codes and present data to the RUC.

The specialties provided an update to the RUC at the January 2004 meeting. The specialties indicated that they plan to survey a representative number of codes from each family of codes to offer evidence that there is a difference in physician work between the excision of benign and malignant lesions. The RUC extensively discussed this issue and raised a number of issues including whether pathology is known prior to the excision and if coding changes would be appropriate to change benign/malignant to superficial/deep. The RUC approved a methodology where the societies would survey one benign and malignant code from each of the three anatomic families (six codes total) to answer the question whether there is a difference in physician work.

After discussions at the January 2004 RUC meeting, specialty society Advisors from the specialties of dermatology, general surgery, otolaryngology, plastic surgery, and podiatry agreed to survey one code from each of the six benign/malignant excision code families. Common vignettes and a common reference list were developed. All six codes were surveyed by dermatology, general surgery, and plastic surgery societies. The two codes that reference *feet* (11423 and 11623) were surveyed by podiatry (utilizing an anatomical variation to the vignette). The four codes that reference *scalp* and *face* (11423; 11443, 11623, and 11643) were surveyed by otolaryngology. The RUC agreed that the results of these surveys respond to CMS' request to prove that there is a difference in physician work for excising benign and malignant lesions with similar diameters.

The RUC did consider comments from the American Academy of Family Physicians regarding a request to further clarify the CPT descriptors for these services. The RUC understands that there may be inconsistent payment policies regarding whether one must wait for a pathology report prior to submitting claims for these services. The RUC suggested that specialties pursue this issue with the CPT Editorial Panel if they believe it to be necessary. The CPT Editorial Panel did discuss this issue at their May 2004 meeting and understands that representatives from Dermatology will submit language to the Panel to clarify the guidelines for these services.

The following specialties were involved in conducting surveys in the summer of 2005 to review each of the excision of lesion codes: dermatology, plastic surgery, general surgery, otolaryngology, and podiatry. Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the RUC utilized the survey data for time for those codes for which there was an adequate sample size and the did their best to extrapolate that data to all codes.

In general, the RUC utilizing the following general principles in reviewing these codes:

1. Pre-time positioning and scrub time is not required for small lesions excised in the office.

2. The intra-service time varies by size of lesion only and remains consistent between anatomical sites.

3. For all but the largest benign lesion, a 99212 would be the typical office visit.

4. All of the malignant lesions require a 99213 in the 010 day global period to discuss the lab report with the patient.

The RUC agrees that the primary difference in the work between the excision of a benign versus a malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.

AMA/Specialty Society RVS Update Committee
RBRVS 2005 Five-Year Review
RUC Recommendations - Dermatology and Plastic Surgery

CPT Code	*Descriptor*	*2005 work RVU*	*RUC Rec Work RVU*	*Comment from the Public*	*RUC Rationale*	*Change in Time from 2005?*	*Action Key*
11100	Biopsy, skin lesion	0.81	0.81	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The survey of 56 dermatologists for this service validated the initial valuation of 0.81 for this service 65% of the survey respondents indicated that the work had not changed. It was noted that although an E/M is reported in association with this service approximately 65% of the time, additional pre-service evaluation time is appropriate specifically related to this service. Additional time for pre-service position and scrub time, however, is not warranted. After making these adjustments, it is recommended that the time elements should be: pre = 5, intra = 12, post = 5, which is consistent with the total Harvard time of 22 minutes. The work rvu recommendation is 0 81.	☑	2

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Action Key (1 = Adopt the recommended increase in the work RVU; 2 = Maintain the current work RVU; 3 = Adopt the recommended decrease in the work RVU; 4 = Suggest a new RVU; 5 = Refer the code to CPT, 6 = No consensus; 7 = Accept withdrawal by commenter, without prejudice; 8 = No Level of Interest submitted, no Recommendation submitted)

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11400	Exc tr-ext b9+marg 0.5<cm	0 85	0.85	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are. 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11401	Exc tr-ext b9+marg 0 6-1cm	1.23	1 23	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11402	Exc tr-ext b9+marg 1.1-2 cm	1.51	1.40	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11403	Exc tr-ext b9+marg 2 1-3 cm	1.79	1 79	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11404	Exc tr-ext b9+marg 3.1-4 cm	2.06	2.06	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11406	Exc tr-ext b9+marg >4 0cm	2 76	3 20	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11420	Exc h-f-nk-sp b9+marg 0.5<	0.98	0 98	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11421	Exc h-f-nk-sp b9+marg 0.6-1	1.42	1.42	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11422	Exc h-f-nk-sp b9+marg 1.1-2	1.63	1 63	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are. 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11423	Exc h-f-nk-sp b9+marg 2 1-3	2.01	2.01	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11424	Exc h-f-nk-sp b9+marg 3 1-4	2 43	2.43	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are· 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11426	Exc h-f-nk-sp b9+marg >4 0 cm	3.77	3 77	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11440	Exc face-mm b9+marg 0.5 < cm	1 06	1.00	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are. 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11441	Exc face-mm b9+marg 0 6-1 cm	1.48	1.48	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are· 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11442	Exc face-mm b9+marg 1.1-2 cm	1.72	1.72	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are. 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11443	Exc face-mm b9+marg 2 1-3 cm	2.29	2.29	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11444	Exc face-mm b9+marg 3.1-4 cm	3 14	3 14	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11446	Exc face-mm b9+marg >4 cm	4.48	4.48	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are· 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2
11450	Removal, sweat gland lesion	2.73		Incorrect assumptions made in previous Harvard evaluation (Family is undervalued, post-operative time is too low, survey needed)	ASPS withdrew the code from the Five-Year Review.	☐	7
11451	Removal, sweat gland lesion	3.94		Incorrect assumptions made in previous Harvard evaluation (Family is undervalued, post-operative time is too low, survey needed)	ASPS withdrew the code from the Five-Year Review.	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11462	Removal, sweat gland lesion	2.51		Incorrect assumptions made in previous Harvard evaluation (Family is undervalued, post-operative time is too low; survey needed)	ASPS withdrew the code from the Five-Year Review	☐	7
11463	Removal, sweat gland lesion	3.94		Incorrect assumptions made in previous Harvard evaluation (Family is undervalued, post-operative time is too low; survey needed)	ASPS withdrew the code from the Five-Year Review.	☐	7
11470	Removal, sweat gland lesion	3.25		Incorrect assumptions made in previous Harvard evaluation (Family is undervalued; post-operative time is too low, survey needed)	ASPS withdrew the code from the Five-Year Review.	☐	7
11471	Removal, sweat gland lesion	4.40		Incorrect assumptions made in previous Harvard evaluation (Family is undervalued, post-operative time is too low; survey needed)	ASPS withdrew the code from the Five-Year Review.	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11600	Exc tr-ext mlg+marg 0 5<cm	1.31	1.31	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11601	Exc tr-ext mlg+marg 0.6-1cm	1.80	1 75	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11602	Exc tr-ext mlg+marg 1.1-2cm	1.95	1.95	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are. 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11603	Exc tr-ext mlg+marg 2.1-3<cm	2.19	2.50	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11604	Exc tr-ext mlg+marg 3 1-4cm	2.40	2 85	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11606	Exc tr-ext mlg+marg >4cm	3.42	4 70	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are· 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document. The intra-service time for this service should be 90 minutes, reflecting a longer intra-service time that other excisions of lesions >4cm as the patients who receive this service most have much larger lesions on the trunk, as they have waited to seek medical treatment. The survey 25th percentile of 4.70 appeared reasonable for this service	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11620	Exc h-f-nk-sp mlg+marg 0 5<	1 19	1.32	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are. 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11621	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	1 76	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11622	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.09	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are. 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11623	Exc h-f-nk-sp mlg+marg 2.1-3	2 61	2.79	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11624	Exc h-f-nk-sp mlg+marg 3.1-4	3 06	3.30	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11626	Exc h-f-nk-sp mlg+marg >4cm	4.29	4.29	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11640	Exc face-mm malig+marg 0.5<	1.35	1 35	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11641	Exc face-mm malig+marg 0.6-1	2.16	1 85	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11642	Exc face-mm malig+marg 1.1-2	2 59	2.30	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11643	Exc face-mm malig+marg 2.1-3	3 10	3 10	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office, 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites; 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11644	Exc face-mm malig+marg 3.1-4	4 02	4 02	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are: 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit, 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient. The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
11646	Exc face-mm malig+marg>4	5.94	5 94	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	Unfortunately, the specialties were only able to collect survey respondents for a small number of individuals for many of the excision of lesion codes. In general, the committee utilized the survey data for time for those codes for which there was an adequate sample size and then did their best to extrapolate that data to all codes. A few general principles in reviewing these codes are 1) pre-time positioning and scrub time is not required for small lesions excised in the office; 2) the intra-service time varies by size of lesion only and remains consistent between anatomical sites, 3) for all but the largest benign lesion, a 99212 would be the typical office visit; 4) all of the malignant lesions require a 99213 in the 10 day global to discuss the lab report with the patient The primary difference in the work between the excision of a benign versus malignant lesion is in the pre-evaluation time (additional planning, discussions with the patient), the intensity of the intra-service time, and the level of post-operative office visit. A spreadsheet summarizing all of the recommended time elements and work relative values is attached to this document.	☑	2
11960	Insert tissue expander (s)	9 07		Incorrect assumptions made in previous valuation (Current vignette does not describe typical patient (a burn or congenital giant nevus is more typical))	ASPS withdrew the code from the Five-Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
12052	Layer closure of wound(s)	2.77	2 77	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The survey of 43 dermatologists, plastic surgeons, and otolaryngologists, for this service validated the initial valuation of 2 77 for this service. Nearly 90% of the survey respondents indicated that the work had not changed. It was noted that although an excision of lesion is always reported with this code, additional pre-service evaluation time is appropriate specifically related to this service to explain the closure to the patient. Additional time for pre-service position and scrub time, however, is not warranted as the physician is already scrubbed and prepped. After making these adjustments, it is recommended that the time elements should be: pre = 5, intra = 28, post = 10, and two 99212 visits for dressing change within 48 hours and to remove the sutures within 10 days. The work rvu recommendation is 2.77.	☑	2
13121	Repair of wound or lesion	4.32	4.32	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The survey of 45 dermatologists, plastic surgeons, and otolaryngologists, for this service validated the initial valuation of 4.32 for this service Nearly 75% of the survey respondents indicated that the work had not changed. It was noted that although an excision of lesion is always reported with this code, additional pre-service evaluation time is appropriate specifically related to this service to explain the closure to the patient. Additional time for pre-service position and scrub time, however, is not warranted as the physician is already scrubbed and prepped. After making these adjustments, it is recommended that the time elements should be pre = 10, intra = 60, post = 15, and two 99212 visits for dressing change within 48 hours and to remove the sutures within 10 days The work rvu recommendation is 4.32 .	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
14040	Skin tissue rearrangement	7 86	7.86	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The survey of 33 dermatologists, plastic surgeons, and otolaryngologists, for this service validated the initial valuation of 7 86 for this service Nearly 75% of the survey respondents indicated that the work had not changed It was noted that an excision is included within this code, therefore, the survey pre-time is appropriate after minor adjustments for consistency. This service is a procedure most typically performed in the physician's office, therefore, the hospital visit time was removed. After making these adjustments, it is recommended that the time elements should be pre = 15 (eval), 10 (positioning), 5 (scrub), intra = 90, post = 25, and two 99213 and two 99212 visits for multiple dressing changes and suture removal within the 90 day global period The work rvu recommendation is 7.86.	☑	2
14060	Skin tissue rearrangement	8.49	8 49	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The survey of 32 dermatologists, plastic surgeons, and otolaryngologists, for this service validated the initial valuation of 8.49 for this service. Nearly 80% of the survey respondents indicated that the work had not changed It was noted that an excision is included within this code, therefore, the survey pre-time is appropriate after minor adjustments for consistency. This service is a procedure most typically performed in the physician's office, therefore, the hospital visit time is not included. After making these adjustments, it is recommended that the time elements should be: pre = 15 (eval), 10 (positioning), 5 (scrub), intra = 60, post = 15, and two 99213 and two 99212 visits for multiple dressing changes and suture removal within the 90 day global period The intra-service component of this service is more intense than 14040, as this service is usually performed near the eyes The work rvu recommendation is 8 49.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
15100	Skin split graft	9.04	9.04	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The survey of 32 plastic surgeons for this service validated the initial valuation of 9.04 for this service. More than 90% of the survey respondents indicated that the work had not changed It is recommended that the time elements should be: pre = 45 (eval), 10 (positioning), 10 (scrub), intra = 60, post = 20, one 99231, one 99238, two 99213, and two 99212 visits for multiple dressing changes and suture removal within the 90 day global period It was noted that this code and the code for which it is most typically billed with, 15000, are not listed as modifier -51 exempt in CPT and it is assumed that most payers would reduce this service if performed in conjunction with another service CMS does not currently apply the multiple surgical reduction to 15000 It is recommended that the time elements should be: pre = 45 (eval), 10 (positioning), 10 (scrub), intra = 60, post = 20, one 99231, one 99238, two 99213, and two 99212 visits for multiple dressing changes and suture removal within the 90 day global period. The 25th percentile of the survey is 9.00 and the total physician time is similar to Harvard, which validates the current work rvu. The work rvu recommendation is 9.04.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
15240	Skin full graft	9 03	9.03	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The specialty only collected 17 responses to their survey of plastic surgery, dermatology, and otolaryngology for this service However, the committee was able to validate the initial valuation of 9 03 for this service. More than 90% of the survey respondents indicated that the work had not changed. It was noted that this is an outpatient procedure, so the discharge day should by ½ 99238 It was noted that 15240 would typically be billed with an excision code. It is assumed that the multiple surgical reduction would be applied when these two codes are reported on the same date by the same physician It is recommended that the time elements should be: pre = 45 (eval), 10 (positioning), 10 (scrub), intra = 60, post = 20, one 99231, one-half 99238, four 99213, and two 99212 visits for multiple dressing changes and suture removal within the 90 day global period. The 25th percentile of the survey is 9.05 and the total physician time is similar to Harvard, which validates the current work rvu. The work rvu recommendation is 9.03	☑	2
15732	Muscle-skin graft, head/neck	17 81		CMS submitted - (2) This service was selected for review because it was valued as being performed in the inpatient setting but that are now predominantly performed on an outpatient basis,	After survey and discussion, it became apparent that this CPT code describes two disparate procedures, allowing both superficial repairs and repair of more serious cancer defects to be reported with 15732. These patient populations require different work, one group of patients are typically provided the service in the inpatient setting and the other group are treated in the outpatient setting. Plastic surgery will coordinate with otolaryngology and ophthalmology to develop a coding proposal to specifically identify these different services in new CPT codes.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
15734	Muscle-skin graft, trunk	17.76	17 76	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	100% of the survey respondents indicated that the work related to this service has not changed. The survey time data is similar to the Harvard time and the estimates of work validate the current work value of 17 76 for this service. The recommended time elements are as follows: pre = 30 (eval), 15 (position), 15 (scrub), intra = 163 (25th %), post = 30, one 99231, one 99232, one 99233, one 99238, two 99212, two 99213, and one 99214. The work rvu recommendation is 17.76.	☑	2
15831	Excise excessive skin tissue	12 38		Change in physician work due to change in patient population (Typical patient has changed from time of original Harvard valuation (largely due to increased gastric bypass surgeries))	A CPT proposal should be completed to capture the new population of patients presenting for excision of excessive skin and subcutaneous tissue in the lower abdomen, because of the tremendous increase in bariatric procedures for massive weight loss.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
17003	Destroy lesions, 2-14	0 15	0.07	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure	The destruction of lesions family includes the following format: 17000 Destruction. . .; first lesion 17003 second through 14 lesions, each 17004 15 or more lesions While 17000 and 17000 are codes with a 10 day global and may only be reported once, 17003 is reported for each lesion. These lesions are most typically actinic keratoses and are destroyed via cryosurgery. It is understood that the actual application of cryosurgery to each lesion requires no more than two minutes of physician time Therefore, the current work relative value of 0.15 overestimates this time-limited, low intensity service The specialty indicated that the typical number of lesions excised in one setting is five A reference service that may be utilized is to determine an appropriate amount of work for this service is 11201 Removal of skin tags, each additional ten lesions (work rvu = .29, time = 8 minutes) Utilizing the .036 of work per minute of time for 11201, it appears reasonable that 17003 should be valued at 0.07. Considering that destruction of five lesions by cryosurgery is considered typical, the total value for this overall service is .88 = (17000 = .60) + (17003 x 4 = 0 28) and the committee determined that to be reasonable for total time elements of pre = 4, intra = 10, and post = 2, and one 99212 The committee noted that the specialties argued that some physicians may used multiple modalities to destroy lesions, which may require more work than cryosurgery. Understanding	☐	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
					that cryosurgery is the dominant method, the committee recommends that the specialty consider coding changes to differentiate this work. Finally, it is understood that a rank order anomaly must be addressed. It is recommended that 17004 be re-evaluated at the February 2006 RUC meeting The recommended work rvu for 17003 is 0 07, with 2 minutes of intra-service time		
17262	Destruction of skin lesions	1.58	1.58	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	A survey of 44 dermatologists validates the current valuation of 17262 at 1.58. More than 80% of the survey respondents indicated that the work had changed for this service The survey time approximates the Harvard time. The survey data collected additional scrub time of 5 minutes is not valid as this is an office procedure that would not typically require these activities. This code is also similar to work captured in CPT 11313 Shave skin lesion (work rvu = 1.62). The current work relative value of 1.58 is recommended for 17262, with time elements of pre = 5 (eval), 3 (positioning), intra = 15; post = 5, one 99212.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
17281	Destruction of skin lesions	1 72	1 72	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	A survey of 49 dermatologists validates the current valuation of 17281 at 1.72 Nearly 80% of the survey respondents indicated that the work had changed for this service. The survey time approximates the Harvard time. The survey data collected additional scrub time of 5 minutes is not valid as this is an office procedure that would not typically require these activities. This code is more work than CPT 11313 Shave skin lesion (work rvu = 1.62). This service is also more intense than 17262 as it involves structures of the face The current work relative value of 1.72 is recommended for 17281, with time elements of pre = 5 (eval), 3 (positioning); intra = 14; post = 5; one 99212.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
17304	1 stage mohs, up to 5 spec	7.59		CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	In February 2003, the RUC recommended the following related to all of Mohs surgery. The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion and anatomical site, rather than the number of specimens The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated To date, there have been no attempts to discuss the Mohs surgery section with the CPT Editorial Panel and efforts to reach consensus within the Mohs surgery community on a coding proposal have been unsuccessful. The committee agreed with the prior conclusions of the RUC and is unable to validate the current work relative values absent a fundamental coding change within this section of CPT	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
17305	2 stage mohs, up to 5 spec	2.85		CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	In February 2003, the RUC recommended the following related to all of Mohs surgery The code descriptors for these services remain confusing and open to various interpretations. Although the RUC understands that many in the Mohs community and payors had historically interpreted CPT code 17310 as an add-on code to be reported for each additional specimen beyond the first five specimens, concern was expressed regarding the potential for over-utilization of this code. In addition, the workgroup noted that the nomenclature for these services is not consistent with other integumentary coding conventions in CPT, which are based on the size of the lesion and anatomical site, rather than the number of specimens The RUC, therefore, recommends that the specialty work with the CPT Editorial Panel to re-define the Mohs Micrographic Surgery section in CPT. After this revision is complete, the RUC believes that these codes can be appropriately re-evaluated To date, there have been no attempts to discuss the Mohs surgery section with the CPT Editorial Panel and efforts to reach consensus within the Mohs surgery community on a coding proposal have been unsuccessful. The committee agreed with the prior conclusions of the RUC and is unable to validate the current work relative values absent a fundamental coding change within this section of CPT.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
19361	Breast reconstruction	19.23		Anomalous relationship with reference codes 15734 and 19367 (Should be valued higher than muscle flap codes due to additional work required with the implant)	ASPS withdrew the code from the Five-Year Review.	☐	7
21145	Reconstruct midface, lefort	19 91	21.84	Anomalous relationship with family of codes (RVU too low compared to others in family without bone graft)	The specialty argued that there was compelling evidence that CPT codes 21145, 21146, 21147, and 21147 had been valued based on an incorrect assumption regarding the value of the bone graft portion of the service The specialty society and the RUC had agreed in April 1995 that the appropriate increment of work was 2.00. The basis for this decision is unclear. The committee agrees that the appropriate increment of work for the bone should be 50% of 20902 (7.54 * 50% = 3.77). 21145, should therefore, be valued as follows: 21141 (18.07)+ 3.77 = 21.84. The committee does not believe that the survey data for time should be entered into the RUC database as it appears that the survey may not have been valid. Finally, the committee suggested that the specialty consider a new code that would specifically capture the work of the cast models. If CPT does not address this issue, the specialty may wish to re-address the issue of pre-time for these services.	☐	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
21146	Reconstruct midface, lefort	20 68	22 55	Anomalous relationship with family of codes (RVU too low compared to others in family without bone graft)	The specialty argued that there was compelling evidence that CPT codes 21145, 21146, 21147, and 21147 had been valued based on an incorrect assumption regarding the value of the bone graft portion of the service The specialty society and the RUC had agreed in April 1995 that the appropriate increment of work was 2.00 The basis for this decision is unclear. The committee agrees that the appropriate increment of work for the bone graft should be 50% of 20902 (7.54 * 50% = 3.77). 21146, should therefore, be valued as follows· 21142 (18.78) + 3 77 = 22 55. The committee does not believe that the survey data for time should be entered into the RUC database as it appears that the survey may not have been valid. Finally, the committee suggested that the specialty consider a new code that would specifically capture the work of the cast models. If CPT does not address this issue, the specialty may wish to re-address the issue of pre-time for these services	☐	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
21147	Reconstruct midface, lefort	21.74	23.32	Anomalous relationship with family of codes (RVU too low compared to others in family without bone graft)	The specialty argued that there was compelling evidence that CPT codes 21145, 21146, 21147, and 21147 had been valued based on an incorrect assumption regarding the value of the bone graft portion of the service. The specialty society and the RUC had agreed in April 1995 that the appropriate increment of work was 2.00. The basis for this decision is unclear The committee agrees that the appropriate increment of work for the bone graft should be 50% of 20902 (7 54 * 50% = 3.77). 21147, should therefore, be valued as follows: 21143 (19 55 + 3.77 = 23.32. The committee does not believe that the survey data for time should be entered into the RUC database as it appears that the survey may not have been valid Finally, the committee suggested that the specialty consider a new code that would specifically capture the work of the cast models. If CPT does not address this issue, the specialty may wish to re-address the issue of pre-time for these services.	☐	4
21365	Treat cheek bone fracture	14.93		Incorrect assumptions made in previous Harvard valuation (intra-service time is too low by approx 60-90 minutes)	ASPS withdrew the code from the Five-Year Review	☐	7
21366	Treat cheek bone fracture	17 74		Incorrect assumptions made in previous valuation (Code needs to be surveyed; includes bone graft)	ASPS withdrew the code from the Five-Year Review.	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
21395	Treat eye socket fracture	12.66	13.88	Anomalous relationship with family of codes (RVU too low compared to others in family without bone graft)	The specialty argued that there was compelling evidence that CPT codes 21145, 21146, 21147, and 21395 had been valued based on an incorrect assumption regarding the value of the bone graft portion of the service The specialty society and the RUC had agreed in April 1995 that the appropriate increment of work was 2.00. The basis for this decision is unclear. The committee agrees that the appropriate increment of work for the bone graft should be 50% of 20902 (7.54 * 50% = 3 77) 21395, should therefore, be valued as follows: 21390 (10 11) + 3.77 = 13 88 The committee agrees that the Medicare data for this service is not reflective of the site-of-service for this procedure. It is an inpatient procedure. The following time elements are recommended: pre. 30 (eval), 15 (position), 15 (scrub); intra = 120, post: 30, one 99231, one 99232, one 99238, two 99212, and two 99213. The work rvu recommendation for 21395 is 13.88	☑	4
21432	Treat craniofacial fracture	8.60		Anomalous relationship with family of codes (inttra-service time is too low, code needs to be surveyed)	ASPS withdrew the code from the Five-Year Review	☐	7
21435	Treat craniofacial fracture	17.22		Anomalous relationship with family of codes (Undervalued compared to code 21433)	ASPS withdrew the code from the Five-Year Review	☐	7
21436	Treat craniofacial fracture	28 00		Anomalous relationship with family of codes (Undervalued compared to code 21433; low intra-service time; involves bone graft; needs to be surveyed)	ASPS withdrew the code from the Five-Year Review.	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
21470	Treat lower jaw fracture	15	32	Anomalous relationship with family of codes (intra-service time too low at only two minutes higher than code 21462, which has fewer components)	ASPS withdrew the code from the Five-Year Review	☐	7
43496	Free jejunum flap, microvasc	0.00		Currently no assigned value (needs to be surveyed; in 1996, the RUC recommended carrier pricing pending a survey with more specific vignettes)	ASPS withdrew the code from the Five-Year Review.	☐	7
49906	Free omental flap, microvasc	0.00		Currently no assigned value (needs to resurveyed; in 1996, the RUC recommended carrier pricing pending a survey with more specific vignettes)	ASPS withdrew the code from the Five-Year Review.	☐	7
96567	Photodynamic tx, skin	0.00		AAD and DUSA commented that the original clinical vignette failed entirely to recognize the degree of pain associated with this treatment and the consequent need for direct physician involvement. This resulted in a decision by the RUC (and CMS) to not assign any physician work relative value for this service. Based upon the substantial change in the nature of this service, AAD and DUSA are requesting reexamination.	AAD withdrew the code from the Five-Year Review.	☐	7

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Action Key (1 = Adopt the recommended increase in the work RVU; 2 = Maintain the current work RVU, 3 = Adopt the recommended decrease in the work RVU, 4 = Suggest a new RVU; 5 = Refer the code to CPT; 6 = No consensus, 7 = Accept withdrawal by commenter, without prejudice, 8 = No Level of Interest submitted, no Recommendation submitted)

CPT Code	CPT Descriptor	Pre-Svc Eval Time	Pre-Svc Position	Pre-Svc Scrub	Intra Time	Immed Post	EM 99212	EM 99213	Total Rec. Time	Current CMS Time	Current Work RVU	Rec. Work RVU	Rec. RVU IWPUT
11400	Exc tr-ext b9+marg 0.5<cm	5			10	5	1		35	47	0.85	0.85	0.020
11401	Exc tr-ext b9+marg 0.6-1cm	10			20	5	1		50	57	1.23	1.23	0.023
11402	Exc tr-ext b9+marg 1.1-2 cm	10			25	5	1		55	59	1.51	**1.40**	0.025
11403	Exc tr-ext b9+marg 2.1-3 cm	10	5	5	30	10	1		75	73	1.79	1.79	0.025
11404	Exc tr-ext b9+marg 3.1-4 cm	10	5	5	40	10	1		85	82	2.06	2.06	0.026
11406	Exc tr-ext b9+marg >4.0cm	10	5	5	60	10		1	113	90	2.76	**3.20**	0.032
11420	Exc h-f-nk-sp b9+marg 0.5<	5			10	5	1		35	50	0.98	0.98	0.033
11421	Exc h-f-nk-sp b9+marg 0.6-1	10			20	5	1		50	56	1.42	1.42	0.033
11422	Exc h-f-nk-sp b9+marg 1.1-2	10			25	5	1		55	61	1.63	1.63	0.035
11423	Exc h-f-nk-sp b9+marg 2.1-3	10	5	5	30	10	1		75	72	2 01	2.01	0.033
11424	Exc h-f-nk-sp b9+marg 3.1-4	10	5	5	40	10	1		85	83	2.43	2.43	0.035
11426	Exc h-f-nk-sp b9+marg >4.0 cm	10	5	5	60	10		1	113	93	3 77	3.77	0.042
11440	Exc face-mm b9+marg 0.5 < cm	5			10	5	1		35	48	1.06	**1.00**	0.035
11441	Exc face-mm b9+marg 0.6-1 cm	10			20	5	1		50	53	1 48	1.48	0.036
11442	Exc face-mm b9+marg 1.1-2 cm	10			25	5	1		55	66	1 72	1.72	0.038
11443	Exc face-mm b9+marg 2.1-3 cm	10	5	5	30	10	1		75	84	2 29	2.29	0.042
11444	Exc face-mm b9+marg 3.1-4 cm	10	5	5	40	10	1		85	102	3 14	3.14	0.053
11446	Exc face-mm b9+marg >4 cm	10	5	5	60	10		1	113	110	4 48	4.48	0.054
11600	Exc tr-ext mlg+marg 0.5<cm	10			10	5		1	48	48	1 31	1.31	0.032
11601	Exc tr-ext mlg+marg 0.6-1cm	15			20	5		1	63	53	1 80	**1.75**	0.033
11602	Exc tr-ext mlg+marg 1.1-2cm	15			25	5		1	68	66	1 95	1 95	0.034
11603	Exc tr-ext mlg+marg 2.1-3<cm	20	5	5	30	10		1	93	78	2 19	**2.50**	0.034

11604	Exc tr-ext mlg+marg 3.1-4cm	20	5	5	40	10		1	103	88	2.40	**2.85**	0.034
11606	Exc tr-ext mlg+marg >4cm	20	5	5	90	10		1	153	102	3.42	**4.70**	0.036
11620	Exc h-f-nk-sp mlg+marg 0.5<	10			10	5		1	48	52	1.19	**1.32**	0.033
11621	Exc h-f-nk-sp mlg+marg 0.6-1	15			20	5		1	63	58	1.76	1.76	0.033
11622	Exc h-f-nk-sp mlg+marg 1.1-2	15			25	5		1	68	72	2.09	2.09	0.040
11623	Exc h-f-nk-sp mlg+marg 2.1-3	20	5	5	30	10		1	93	84	2.61	**2.79**	0.044
11624	Exc h-f-nk-sp mlg+marg 3.1-4	20	5	5	40	10		1	103	93	3.06	**3.30**	0.046
11626	Exc h-f-nk-sp mlg+marg >4cm	20	5	5	60	10		1	123	109	4.29	4 29	0.047
11640	Exc face-mm malig+marg 0.5<	10			10	5		1	48	51	1.35	1.35	0.036
11641	Exc face-mm malig+marg 0.6-1	15			20	5		1	63	66	2.16	**1.85**	0.038
11642	Exc face-mm malig+marg 1.1-2	15			25	5		1	68	86	2.59	**2.30**	0.048
11643	Exc face-mm malig+marg 2.1-3	20	5	5	30	10		1	93	100	3.10	3 10	0.054
11644	Exc face-mm malig+marg 3 1-4	20	5	5	45	10		1	108	112	4.02	4 02	0.057
11646	Exc face-mm malig+marg>4	20	5	5	65	10		1	128	130	5.94	5 94	0.069

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11100 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **1.0**
RUC RVU: **0.81**

CPT Descriptor: Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58 year old woman presents with an indurated patch on the forehead The differential includes a morpheaform basal cell carcinoma and a granuloma of unknown etiology.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Prior to biopsy of lesion, obtain pertinent history from patient to include: previous skin cancer, prior treatment history, sun protection history, etc. Discussion with patient will include. indication for biopsy procedure, risks, and benefits; description of biopsy procedure method, and expected result and/or scarring In addition, patient agreement/informed consent is obtained and staff is advised for preparation of patient and necessary anesthetic, supplies, and instrument tray preparation.

Description of Intra-Service Work: Intra-service work includes: inspection and palpation of the lesion to assess depth and to select most representative site to obtain specimen. Cleanse biopsy site with suitable antiseptic; inject appropriate local anesthetic; apply sterile drapes; obtain skin specimen with scalpel, skin punch, or suitable instrument depending on depth and amount of tissue needed. Collect specimen in labeled formalin container. Undermine wound edges as needed to facilitate repair. Suture to approximate wound edges, or achieve hemostasis with pressure, chemical, or electrocautery, or application of topical hemostatic agents. Apply antibiotic ointment and sterile dressing.

Description of Post-Service Work: Post-service work includes: instruction of patient and/or family on postoperative wound care, dressing changes, and follow-up. Patient advised how to recognize significant complications, eg, bleeding, or allergic reaction to antibiotic ointment or adhesive dressings. Patient advised when results will be available and how they will be communicated; completion of medical record; and communication of results to referring physician as appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A. Zalla, MD Bruce Deitchman, MD Brett Coldiron, MD				
Specialty(s):	Dermatology				
CPT Code:	11100				
Sample Size: 250	**Resp n:** 56	**Response:** 22.4 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	0.60	0.85	**1.00**	1.21	1.90
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		

code 11100

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		8.00	10.00	**12.00**	15.00	25 00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	5.00					
Critical Care time/visit(s):	0.0	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	0.0	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	0.0	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	0.0	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
1301	000	0.85

CPT Descriptor Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.6 to 1 0 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11755	000	1.31

CPT Descriptor 1 Biopsy of nail unit (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

MPC CPT Code 2	Global	Work RVU
10060	010	1.17

CPT Descriptor 2 Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 30.3 %

TIME ESTIMATES (Median)	**CPT Code: 11100**	**Key Reference CPT Code: 11301**
Median Pre-Service Time	5.00	11.00
Median Intra-Service Time	12.00	13.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0 0	0 00
Median Discharge Day Management Time	0 0	0 00
Median Office Visit Time	0 0	0 00
Median Total Time	**22.00**	**29.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
Physical effort required	3.00	3 00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3 00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	3 00	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation

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SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 35% No 65%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 10% I do not agree 90%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11100

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		12.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 8.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		12.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 8.0	Staff % of Physician time **Change:** **In Time** 67% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11400 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.13**
RUC RVU: **0.85**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of of an atypical pigmented nevus on the waistline with excised diameter of 0.45 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD					
Specialty(s):	AAD					
CPT Code:	11400					
Sample Size:	80	**Resp n:** 8		**Response:** 10.0 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.85	0.96	**1.13**	1 57	2 50
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**0.0**		

code 11400

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		10.00	14.50	**10.00**	15.75	20.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**15.0**	99211x **0.0**	12x **1.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2011	010	1.76

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	**CPT Code: 11400**	**Key Reference CPT Code: 12011**
Median Pre-Service Time	5.00	6.00
Median Intra-Service Time	10.00	22.00
Median Immediate Post-service Time	5.00	6.00
Median Critical Care Time	0 0	0.00
Median Other Hospital Visit Time	0.0	0 00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	9.00
Median Total Time	**35.00**	**43.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2 00	2 25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.38	2.25
Urgency of medical decision making	2.12	2.25

Technical Skill/Physical Effort (Mean)

Technical skill required	2.50	2.88
Physical effort required	2.38	2 75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.00
Outcome depends on the skill and judgment of physician	2.50	2.50
Estimated risk of malpractice suit with poor outcome	2.13	2.25

NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.57	2.38
Intra-Service intensity/complexity	2.43	2.88
Post-Service intensity/complexity	2.57	2.38

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has ırveyed this code using one or more panels of members within this organization. The data collected has been reviewed ,y the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 12% No 87%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11400

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		16.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 9.0	Staff % of Physician time 56%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		10.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 6.0	Staff % of Physician time **Change: In Time** 56% -3.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11401 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.43**
RUC RVU: **1.23**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of of an atypical pigmented nevus on the waistline with excised diameter of 0.90 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005		
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD		
Specialty(s):	AAD		
CPT Code:	11401		
Sample Size: 80	**Resp n:** 8	**Response:** 10.0 %	
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.30	1.33	**1.43**	2.09	2.60
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		

code 11401

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		18.00	20.00	**20.00**	24.25	25.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**15.0**	99211x **0.0**	12x **1.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2011	010	1.76

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1 86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 37.5 %

TIME ESTIMATES (Median)	**CPT Code: 11401**	**Key Reference CPT Code: 12011**
Median Pre-Service Time	10.00	6.00
Median Intra-Service Time	20.00	22.00
Median Immediate Post-service Time	5.00	6.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	9.00
Median Total Time	**50.00**	**43.00**

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.33	2.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2 50	2 33
Urgency of medical decision making	2.33	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	2.50	2.66
Physical effort required	2.50	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.33
Outcome depends on the skill and judgment of physician	2.83	2.50
Estimated risk of malpractice suit with poor outcome	2.66	2.33

NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.33	2.33
Intra-Service intensity/complexity	2.66	2.66
Post-Service intensity/complexity	2.33	2.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has urveyed this code using one or more panels of members within this organization. The data collected has been reviewed y the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 20% No 80%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11401

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		22.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 11.0	Staff % of Physician time 50%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		20.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 10.0	Staff % of Physician time **Change:** **In Time** 50% -1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11402 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.80**
RUC RVU: **1.40**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of of an atypical pigmented nevus on the waistline with excised diameter of 0.90 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics. if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD					
Specialty(s):	AAD					
CPT Code:	11402					
Sample Size:	80	**Resp n:** 7		**Response:** 8.7 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
urvey RVW:		1.60	1.69	**1.80**	2.10	2.61
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**0.0**		

code 11402

Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		15.00	18.00	**25.00**	25.00	30.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**15.0**	99211x **0.0**	12x **1.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23), 99212 (15); 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2001	010	1.70

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 57.1 %

TIME ESTIMATES (Median)	CPT Code: 11402	Key Reference CPT Code: 12001
Median Pre-Service Time	10.00	5.00
Median Intra-Service Time	25.00	18.00
Median Immediate Post-service Time	5 00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0 0	0.00
Median Office Visit Time	15.0	8.00
Median Total Time	**55.00**	**36.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.29	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.43
Urgency of medical decision making	2.29	2.14

Technical Skill/Physical Effort (Mean)

Technical skill required	2 71	2.86
Physical effort required	3.00	3.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.43	2.29
Outcome depends on the skill and judgment of physician	2.86	2.43
Estimated risk of malpractice suit with poor outcome	2.43	2.29

NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.71	2.57
Intra-Service intensity/complexity	2.86	3.00
Post-Service intensity/complexity	2.86	2 86

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11402

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		24.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time. 16.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 16.0	Staff % of Physician time **Change:** **In Time** 67% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11403 | Global Period: 010 | **Recommended Work Relative Value**
Specialty Society RVU **2.20**
RUC RVU. **1.79**

CPT Descriptor: Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of a biopsy-proven, atypical pigmented nevus on the waistline with excised diameter of 2.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review pre-operative work up, paying special attention to pathology report.
- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient.
- Indicate area of skin to be prepped and draped.
  Trim hair with scissors over and around lesion.
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take effect.

Description of Intra-Service Work:
An elliptical incision is made around the entire lesion (excisional biopsy) with a 2mm margin of normal skin. The dissection is full thickness and includes some subcutaneous fat. Hemostasis is meticulous and electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work:
Day of procedure:
- Apply sterile dressing.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms.

In office after procedure:
- Review pathology report and chart
- Talk with patient and other family members.
  Check wound and remove sutures/staples.
- Advise patient on sun exposure risks, the need for monthly self examinations, the need for follow-up care to detect the occurrence of other lesions, and the potential risk of FAMMM (genetic syndrome)
- Answer patient/family questions

Dictate progress notes for medical records and communicate with referring/ family physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD					
Specialty(s):	General Surgery, Plastic Surgery, Dermatology					
CPT Code:	11403					
Sample Size:	250	**Resp n:** 84		**Response:** 33.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.01	1.90	**2.20**	2.24	4.50
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		10.00	20.00	**30.00**	35.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2004	010	2.24

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 22.6 %

TIME ESTIMATES (Median)	CPT Code: 11403	Key Reference CPT Code: 12004
Median Pre-Service Time	20.00	7.00
Median Intra-Service Time	30 00	37.00
Median Immediate Post-service Time	10.00	7 00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	15.00
Median Total Time	**75.00**	**66.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.90	1.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.80	1.22
Urgency of medical decision making	1.40	1 56

Technical Skill/Physical Effort (Mean)

Technical skill required	2 10	1 67
Physical effort required	1.60	1 56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.60	1.44
Outcome depends on the skill and judgment of physician	1.90	1.67
Estimated risk of malpractice suit with poor outcome	1 90	1.67

NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.50	2.50
Intra-Service intensity/complexity	2.50	2.50
Post-Service intensity/complexity	1.50	1.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Please see attached multi-specialty letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11403

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		31.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 20.0	Staff % of Physician time 65%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 20.0	Staff % of Physician time **Change:** **In Time** 65% 0 0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11404 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.61**
RUC RVU: **2.06**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 3.1 to 4.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of a biopsy-proven, atypical pigmented nevus on the waistline with excised diameter of 3.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review pre-operative work up, paying special attention to pathology report.
- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient
  Indicate area of skin to be prepped and draped.
- Trim hair with scissors over and around lesion
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take effect.

Description of Intra-Service Work:
An elliptical incision is made around the entire lesion (excisional biopsy) with a 2mm margin of normal skin. The dissection is full thickness and includes some subcutaneous fat. Hemostasis is meticulous and electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work: Day of procedure:
- Apply sterile dressing.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms.

In office after procedure:
- Review pathology report and chart
- Talk with patient and other family members.
  Check wound and remove sutures/staples.
  Advise patient on sun exposure risks, the need for monthly self examinations, the need for follow-up care to detect the occurrence of other lesions, and the potential risk of FAMMM (genetic syndrome)
- Answer patient/family questions

Dictate progress notes for medical records and communicate with referring/ family physician..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD				
Specialty(s):	General Surgery, Plastic Surgery, Dermatology				
CPT Code:	11404				
Sample Size: 250	**Resp n:** 41	**Response:** 16.4 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	2.10	2.46	**2.61**	2.61	4 10
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
Intra-Service Time:	15.00	35.00	**40.00**	40.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	10.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	15.0	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
1770	010	2 61

CPT Descriptor Excision of pilonidal cyst or sinus; simple

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 41.4 %

TIME ESTIMATES (Median)	**CPT Code: 11404**	**Key Reference CPT Code: 11770**
Median Pre-Service Time	20.00	9.00
Median Intra-Service Time	40.00	37.00
Median Immediate Post-service Time	10.00	9.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	15.00
Median Total Time	**85.00**	**70.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.00	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.67	1.67
Urgency of medical decision making	1.67	1.67

Technical Skill/Physical Effort (Mean)

Technical skill required	2.33	2.33
Physical effort required	2.00	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2 00
Outcome depends on the skill and judgment of physician	2.67	2.67
Estimated risk of malpractice suit with poor outcome	2.67	2.67

NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.33	2.33
Intra-Service intensity/complexity	2.33	2.33
Post-Service intensity/complexity	2 33	2.33

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

See attached multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

Jse the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11404

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		39.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 26.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1 0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		40.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 27.0	Staff % of Physician time **Change:** **In Time** 67% 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:11406 Global Period: 010 Specialty Society RVU **3.80**

RUC RVU **3.20**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of a biopsy-proven, atypical pigmented nevus on the waistline with excised diameter of 4.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code?

Description of Pre-Service Work: · Review pre-operative work up, paying special attention to pathology report.

- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient.
- Indicate area of skin to be prepped and draped.
  Trim hair with scissors over and around lesion.
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take effect.

Description of Intra-Service Work:
An elliptical incision is made around the entire lesion (excisional biopsy) with a 2mm margin of normal skin. The dissection is full thickness and includes some subcutaneous fat. Hemostasis is meticulous and electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work:
Day of procedure:

- Apply sterile dressing.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms.

In office after procedure:

- Review pathology report and chart
  Talk with patient and other family members.
  Check wound and remove sutures/staples.
- Advise patient on sun exposure risks, the need for monthly self examinations, the need for follow-up care to detect the occurrence of other lesions, and the potential risk of FAMMM (genetic syndrome)

- Answer patient/family questions
- Dictate progress notes for medical records and communicate with referring/ family physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD					
Specialty(s):	General Surgery, Plastic Surgery, Dermatology					
CPT Code:	11406					
Sample Size: 250	**Resp n:** 41		**Response:** 16.4 %			
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	2.25	3.78	**3.80**	3.91	6.00	
Pre-Service Evaluation Time:			**10.0**			
Pre-Service Positioning Time:			**5.0**			
Pre-Service Scrub, Dress, Wait Time:			**5.0**			
Intra-Service Time:	20.00	54.00	**60.00**	60.00	90.00	
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3101	010	3.91

CPT Descriptor Repair, complex, trunk; 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 31 7 %

TIME ESTIMATES (Median)	**CPT Code: 11406**	**Key Reference CPT Code: 13101**
Median Pre-Service Time	20 00	21.00
Median Intra-Service Time	60.00	53.00
Median Immediate Post-service Time	10.00	21.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0 0	0.00
Median Office Visit Time	23.0	15 00
Median Total Time	**113.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.30	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.67	1 67
Urgency of medical decision making	2.00	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.00
Physical effort required	2.33	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2 33	2 33
Outcome depends on the skill and judgment of physician	3.00	3 00
Estimated risk of malpractice suit with poor outcome	3.00	3 00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.67	2.65
Intra-Service intensity/complexity	2.65	2.67
Post-Service intensity/complexity	2.65	2.60

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
See attached multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code
   - ☐ Different specialties work together to accomplish the procedure, each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11406

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		46.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 31.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 40.0	Staff % of Physician time **Change:** **In Time** 67% 9.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:11420 Global Period: 010 Specialty Society RVU: **1.5**

RUC RVU: **0.98**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, necks, hands, feet, genitalia; excised diameter 0.5 cm or less

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of an atypical pigmented nevus on the scalp with excised diameter of 0.45 cm.

APMA Vignette A 35 year old male presents for removal of an atypical pigmented nevus on the plantar aspect of the foot with excised diameter of 0.45 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD					
Specialty(s):	AAD APMA					
CPT Code:	11420					
Sample Size:	80	**Resp n:** 27		**Response:** 33.7 %		
ample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.00	1.30	**1.50**	2.15	2.50

Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
ıtra-Service Time:	5.00	10.00	**10.00**	17.50	20.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
0120	010	1.22

CPT Descriptor Incision and removal of foreign body, subcutaneous tissues; simple

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
11200	010	0 77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 40.7 %

TIME ESTIMATES (Median)	**CPT Code: 11420**	**Key Reference CPT Code: 10120**
Median Pre-Service Time	5.00	7.00
Median Intra-Service Time	10.00	18.00
Median Immediate Post-service Time	5.00	7.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	6.00
Median Total Time	**35.00**	**38.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

'he number of possible diagnosis and/or the number of management options that must be considered	2 37	2 29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.14	2.11
Urgency of medical decision making	2.14	2.06

Technical Skill/Physical Effort (Mean)

Technical skill required	2.42	2.33
Physical effort required	2.28	2.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.42	2.06
Outcome depends on the skill and judgment of physician	2.57	2.11
Estimated risk of malpractice suit with poor outcome	2.16	2.06

,NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.29	2.14
Intra-Service intensity/complexity	2.29	2.05
Post-Service intensity/complexity	2.29	2.14

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD) and the `merican Podiatric Medicine Association have surveyed this code using one or more panels of members within these ,rganizations. The data collected has been reviewed by the respective societies' RBRVS committees and is presented here as their joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11420

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		18.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 12.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations, use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		10.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 7.0	Staff % of Physician time **Change: In Time** 67% -3.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11421 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.15**
RUC RVU: **1.42**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, necks, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of an atypical pigmented nevus on the scalp with excised diameter of 0.90 cm.

APMA Vignette : A 35 year old male presents for removal of an atypical pigmented nevus on the plantar aspect of the foot with excised diameter of 0.90 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD				
Specialty(s):	AAD APMA				
CPT Code:	11421				
Sample Size: 80	**Resp n:** 28	**Response:** 35.0 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	1.50	1.75	**2.15**	2.18	2.60
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		

code 11421

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		9.00	11.00	**20.00**	22.00	24.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**15.0**	99211x **0.0**	12x **1.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2001	010	1.70

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 28.5 %

TIME ESTIMATES (Median)	**CPT Code: 11421**	**Key Reference CPT Code: 12001**
Median Pre-Service Time	10.00	5.00
Median Intra-Service Time	20.00	18 00
Median Immediate Post-service Time	5.00	5 00
Median Critical Care Time	0 0	0 00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	8.00
Median Total Time	**50.00**	**36.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.43	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.29	2.29
Urgency of medical decision making	2.29	2.57

Technical Skill/Physical Effort (Mean)

Technical skill required	2.57	2.57
Physical effort required	2.57	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.29	2.71
Outcome depends on the skill and judgment of physician	2.71	2.57
Estimated risk of malpractice suit with poor outcome	2.29	2 14

NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.29	2 29
Intra-Service intensity/complexity	2.29	2.29
Post-Service intensity/complexity	2.29	2.29

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD) and the merican Podiatric Medicine Association have surveyed this code using one or more panels of members within these rganizations. The data collected has been reviewed by the respective societies' RBRVS committees and is presented here as their joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 7% No 93%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11421

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		22.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 15.0	Staff % of Physician time 68%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		20.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 14.0	Staff % of Physician time **Change: In Time** 68% -1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11422 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.25**
RUC RVU: **1.63**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, necks, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of a biopsy-proven atypical pigmented nevus on the scalp with excised diameter of 1.6 cm.

APMA Vignette :: A 35 year old male presents for removal of a biopsy-proven atypical pigmented nevus on the plantar aspect of the foot with excised diameter of 1.6 cm. .

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005		
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD		
Specialty(s):	AAD APMA		
CPT Code:	11422		
Sample Size:	80	**Resp n:** 27	**Response:** 33.7 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1 60	2.00	**2.25**	2.75	3.50
Pre-Service Evaluation Time:			**10.0**		

Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	15.00	**25.00**	30.00	40.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2001	010	1.70

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1 86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 25.9 %

TIME ESTIMATES (Median)	**CPT Code: 11422**	**Key Reference CPT Code: 12001**
Median Pre-Service Time	10.00	5.00
Median Intra-Service Time	25.00	18.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	8.00
Median Total Time	**55.00**	**36.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.33	2.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.17	2.39
Urgency of medical decision making	2.33	2.25

Technical Skill/Physical Effort (Mean)

Technical skill required	2.83	2.78
Physical effort required	2.83	2.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.33	2.25
Outcome depends on the skill and judgment of physician	2.83	2 50
Estimated risk of malpractice suit with poor outcome	2.33	2.28

NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.50	2.20
Intra-Service intensity/complexity	2.83	2.58
Post-Service intensity/complexity	2.50	2.11

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD) and the merican Podiatric Medicine Association have surveyed this code using one or more panels of members within these rganizations. The data collected has been reviewed by the respective societies' RBRVS committees and is presented here as their joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 22% No 88%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11422

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time. 17.0	Staff % of Physician time 68%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time **Change:** **In Time** 68% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11423 | Global Period: 010 | **Recommended Work Relative Value**
Specialty Society RVU: **2.24**
RUC RVU: **2.01**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of a biopsy-proven atypical pigmented nevus on the scalp with excised diameter of 2.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 50%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review pre-operative work up, paying special attention to pathology report.
- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient.
  Indicate area of scalp to be prepped and draped.
- Trim hair with scissors over and around lesion.
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take

Description of Intra-Service Work:
An elliptical incision is made around the entire lesion (excisional biopsy) with a 2mm margin of normal skin. The dissection is full thickness and includes some subcutaneous fat. Hemostasis is meticulous and electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work:
Day of procedure:
- Apply sterile dressing.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms.

In office after procedure:
- Review pathology report and chart
  Talk with patient and other family members.
- Check wound and remove sutures/staples.
- Advise patient on sun exposure risks, the need for monthly self examinations, the need for follow-up care to detect the occurrence of other lesions, and the potential risk of FAMMM (genetic syndrome)

- Answer patient/family questions
- Dictate progress notes for medical records and communicate with referring/ family physician

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD					
Specialty(s):	General Surgery, Plastic Surgery, Dermatology					
CPT Code:	11423					
Sample Size:	250	**Resp n:** 91		**Response:** 36 4 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.30	2.15	**2.24**	2.50	4.50
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		7.00	25.00	**30.00**	35.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2004	010	2.24

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 26.3 %

TIME ESTIMATES (Median)	CPT Code: 11423	Key Reference CPT Code: 12004
Median Pre-Service Time	20.00	7.00
Median Intra-Service Time	30 00	37.00
Median Immediate Post-service Time	10.00	7.00
Median Critical Care Time	0.0	0 00
Median Other Hospital Visit Time	0 0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	15 00
Median Total Time	**75.00**	**66.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.38	1.94
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.18	1.83
Urgency of medical decision making	1.85	1.86

Technical Skill/Physical Effort (Mean)

Technical skill required	2.63	2.47
Physical effort required	2.25	2.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.18	2.03
Outcome depends on the skill and judgment of physician	2.38	2.36
Estimated risk of malpractice suit with poor outcome	2.23	2.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2 05	2 06
Intra-Service intensity/complexity	2.51	2.31
Post-Service intensity/complexity	1.85	1 89

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
See attached multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11423

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		32.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 21.0	Staff % of Physician time 66%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 20.0	Staff % of Physician time **Change:** **In Time** 66% 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11424 | Global Period: 010 | **Recommended Work Relative Value**
Specialty Society RVU: **2.61**
RUC RVU: **2.43**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of a biopsy-proven atypical pigmented nevus on the scalp with excised diameter of 3.6 cm..

Percentage of Survey Respondents who found Vignette to be Typical: 6000%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review pre-operative work up, paying special attention to pathology report.
- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient.
  Indicate area of scalp to be prepped and draped.
- Trim hair with scissors over and around lesion.
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take effect.

Description of Intra-Service Work:
An elliptical incision is made around the entire lesion (excisional biopsy) with a 2mm margin of normal skin. The dissection is full thickness and includes some subcutaneous fat. Hemostasis is meticulous and electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work:
Day of procedure:
- Apply sterile dressing.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms

In office after procedure:
- Review pathology report and chart
  Talk with patient and other family members.
- Check wound and remove sutures/staples.
- Advise patient on sun exposure risks, the need for monthly self examinations, the need for follow-up care to detect the occurrence of other lesions, and the potential risk of FAMMM (genetic syndrome)

- Answer patient/family questions
- Dictate progress notes for medical records and communicate with referring/ family physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD					
Specialty(s):	General Surgery, Plastic Surgery, Dermatology					
CPT Code:	11424					
Sample Size:	250	**Resp n:** 41		**Response:** 16.4 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.45	2.61	**2.61**	2 69	3.50
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		16.00	35.00	**40.00**	40 00	46 00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
1770	010	2.61

CPT Descriptor Excision of pilonidal cyst or sinus; simple

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 60.9 %

TIME ESTIMATES (Median)

	CPT Code: 11424	**Key Reference CPT Code: 11770**
Median Pre-Service Time	20.00	9 00
Median Intra-Service Time	40.00	37.00
Median Immediate Post-service Time	10.00	9.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	15.00
Median Total Time	**85.00**	**70.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.50	1.51
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.25	1.50
Urgency of medical decision making	2.00	1.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.00
Physical effort required	3.00	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2 50	2 00
Outcome depends on the skill and judgment of physician	3.00	2.50
Estimated risk of malpractice suit with poor outcome	3.75	2.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.00	1.00
Intra-Service intensity/complexity	3.00	2.00
Post-Service intensity/complexity	2.25	1.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
See attached multi-specialty letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11424

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		39.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 26.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		40.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 27.0	Staff % of Physician time **Change:** **In Time** 67% 1 0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11426 | Global Period: 010 | **Recommended Work Relative Value**
Specialty Society RVU: **3.78**
RUC RVU: **3.77**

CPT Descriptor: Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old male presents for removal of a biopsy-proven atypical pigmented nevus on the scalp with excised diameter of 4.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 55%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review pre-operative work up, paying special attention to pathology report.
- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient.
  Indicate area of scalp to be prepped and draped.
- Trim hair with scissors over and around lesion.
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take effect.

Description of Intra-Service Work:
An elliptical incision is made around the entire lesion (excisional biopsy) with a 2mm margin of normal skin. The dissection is full thickness and includes some subcutaneous fat. Hemostasis is meticulous and electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work:
Day of procedure:

- Apply sterile dressing.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms.

In office after procedure:

- Review pathology report and chart
- Talk with patient and other family members.
- Check wound and remove sutures/staples.

- Advise patient on sun exposure risks, the need for monthly self examinations, the need for follow-up care to detect the occurrence of other lesions, and the potential risk of FAMMM (genetic syndrome)
- Answer patient/family questions
- Dictate progress notes for medical records and communicate with referring/ family physician

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD					
Specialty(s):	General Surgery, Plastic Surgery, Dermatology					
CPT Code:	11426					
Sample Size:	250	**Resp n:** 41		**Response:** 16.4 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		3.25	3 78	**3.78**	3.80	4.50
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		20.00	55.00	**60.00**	60.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3131	010	3.78

CPT Descriptor Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 51.2 %

TIME ESTIMATES (Median)	**CPT Code: 11426**	**Key Reference CPT Code: 13131**
Median Pre-Service Time	20.00	19.00
Median Intra-Service Time	60.00	43.00
Median Immediate Post-service Time	10.00	19.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	15 00
Median Total Time	**113.00**	**96.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.25	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.25
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.25	4.00
Physical effort required	3.50	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.75	3.00
Outcome depends on the skill and judgment of physician	3.00	3.25
Estimated risk of malpractice suit with poor outcome	3.00	3.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3 25	3.50
Intra-Service intensity/complexity	4.00	4.00
Post-Service intensity/complexity	4.00	4.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

See attached cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11426

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		47.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 31.0	Staff % of Physician time 66%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 40.0	Staff % of Physician time **Change: In Time** 66% 9.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11440 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.65**
RUC RVU: **1.00**

CPT Descriptor: Excision, other benign lesion including margins, (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous, membrane; excised diameter 0.5 cm or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old man presents for removal of an atypical pigmented nevus on the left zygomatic area of the cheek with excised diameter of 0.45 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 55%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD				
Specialty(s):	AAD				
CPT Code:	11440				
Sample Size:	80	**Resp n:** 8	**Response:** 10 0 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	1.00	1 19	**1.65**	2.35	3.44
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	13.00	15 00	**10.00**	20 50	25 00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2011	010	1.76

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0 77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1 86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	CPT Code: 11440	Key Reference CPT Code: 12011
Median Pre-Service Time	5.00	6.00
Median Intra-Service Time	10.00	22.00
Median Immediate Post-service Time	5.00	6.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	9.00
Median Total Time	**35.00**	**43.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

'he number of possible diagnosis and/or the number of management options that must be considered	2 38	2 25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.38	2.50
Urgency of medical decision making	2.38	2.38

Technical Skill/Physical Effort (Mean)

Technical skill required	2 88	3.00
Physical effort required	2.43	2.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.63	2.63
Outcome depends on the skill and judgment of physician	3.00	2.88
Estimated risk of malpractice suit with poor outcome	2.75	2.38

.NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.50	2.38
Intra-Service intensity/complexity	2.75	2.75
Post-Service intensity/complexity	2.50	2.63

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has irveyed this code using one or more panels of members within this organization. The data collected has been reviewed ,y the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11440

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		17.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 11.0	Staff % of Physician time 65%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations, use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		10.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 7.0	Staff % of Physician time **Change:** **In Time** 65% -4 0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11441 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.83**
RUC RVU: **1.48**

CPT Descriptor: Excision, other benign lesion including margins, (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous, membrane; excised diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old man presents for removal of an atypical pigmented nevus on the left zygomatic area of the cheek with excised diameter of 0.90 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A Zalla, MD, Bruce Deitchman, MD and James Denney III, MD				
Specialty(s):	AAD AAO-HNSF				
CPT Code:	11441				
Sample Size:	80	**Resp n:** 8	**Response:** 10.0 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	1.50	1.79	**1.83**	2.41	3.47
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	12.00	**20.00**	23.50	28.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2011	010	1.76

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	**CPT Code: 11441**	**Key Reference CPT Code: 12011**
Median Pre-Service Time	10.00	6.00
Median Intra-Service Time	20 00	22.00
Median Immediate Post-service Time	5.00	6.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	9.00
Median Total Time	**50.00**	**43.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.50	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.63
Urgency of medical decision making	2.63	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3 00	3.00
Physical effort required	2.75	2.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.25	2.88
Outcome depends on the skill and judgment of physician	3.25	3.12
Estimated risk of malpractice suit with poor outcome	3.00	2.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.63	2.75
Intra-Service intensity/complexity	3 00	3.00
Post-Service intensity/complexity	2.63	2.88

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11441

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		19 00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 13.0	Staff % of Physician time 68%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		20.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 14.0	Staff % of Physician time **Change:** **In Time** 68% 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11442 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU. **2.0**
RUC RVU· **1.72**

CPT Descriptor: Excision, other benign lesion including margins, (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous, membrane; excised diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old man presents for removal of a biopsy proven atypical pigmented nevus on the left zygomatic area of the cheek with excised diameter of 1.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-Service: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: Intra Service: The physician cleanses the area with dermalogical surgery scrub, and with a sterile surgical marker delineates the extent of the excision including appropriate margins. Physician then injects with local anesthetic.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. The area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post-service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD				
Specialty(s):	AAD				
CPT Code:	11442				
Sample Size:	80	**Resp n:** 8	**Response:** 10.0 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	1.75	1.82	**2.00**	2.80	3.76
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	16.00	23.50	**25.00**	32.00	35.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2011	010	1.76

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	**CPT Code: 11442**	**Key Reference CPT Code: 12011**
Median Pre-Service Time	10 00	6.00
Median Intra-Service Time	25.00	22.00
Median Immediate Post-service Time	5.00	6.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	9.00
Median Total Time	**55.00**	**43.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.88	2.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.57	2.88
Urgency of medical decision making	2.29	2 43

Technical Skill/Physical Effort (Mean)

Technical skill required	3.14	3.14
Physical effort required	2.88	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.86	2.57
Outcome depends on the skill and judgment of physician	2.86	2.71
Estimated risk of malpractice suit with poor outcome	2.86	2.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.71	2.71
Intra-Service intensity/complexity	3.29	3.29
Post-Service intensity/complexity	2.57	2.57

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 12% No 87%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11442

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		29.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 19.0	Staff % of Physician time 66%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time **Change: In Time** 66% -2.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11443 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.73**
RUC RVU: **2.29**

CPT Descriptor: Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old man presents for removal of a biopsy-proven atypical pigmented nevus on the left zygomatic area of the cheek with excised diamter of 2.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: The physician cleanses the area with betadine, and with a sterile surgical marker delineates the extent of the excision. Physician then injects with local anesthetic

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Undermining as necessary to ease wound tension is performed. The wound is closed in one layer using non absorbable suture. The area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD; James Denneny, III, MD					
Specialty(s):	AAD, ASPS, AAOHNS					
CPT Code:	11443					
Sample Size:	200	**Resp n:** 56		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.76	2.40	**2.73**	3.75	9.00
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		

code11443

Intra-Service Time:		8.00	24.00	**30.00**	45.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2051	010	2 47

CPT Descriptor Layer closure of wounds of face; ears, eyelids, nose, lips, and/or mucous membranes, 2 5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 26.7 %

TIME ESTIMATES (Median)	CPT Code: 11443	Key Reference CPT Code: 12051
Median Pre-Service Time	20.00	8.00
Median Intra-Service Time	30.00	24.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	15.00
Median Total Time	**75.00**	**47.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.70	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.29	2.00
Urgency of medical decision making	2.03	2.03

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.76
Physical effort required	2.50	2.41

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.85	2.38
Outcome depends on the skill and judgment of physician	3.03	2.76
Estimated risk of malpractice suit with poor outcome	2.88	2.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.68	2.38
Intra-Service intensity/complexity	2.94	2.65
Post-Service intensity/complexity	2.09	2.09

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Please see accompanying multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11443

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		40.00	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 27.0	Staff % of Physician time 68%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 20.0	Staff % of Physician time **Change:** **In Time** 68% -7.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11444 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU. **3.30**
RUC RVU: **3.14**

CPT Descriptor: Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 3.1 to 4.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old man presents for removal of a biopsy-proven atypical pigmented nevus on the left zygomatic area of the cheek with excised diamter of 3.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: The physician cleanses the area with betadine, and with a sterile surgical marker delineates the extent of the excision. Physician then injects with local anesthetic.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Undermining as necessary to ease wound tension is performed. The wound is closed in one layer using non absorbable suture. The area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD					
Specialty(s):	AAD, ASPS					
CPT Code:	11444					
Sample Size:	200	**Resp n:** 7		**Response:** 0.00 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	2.50	2.94	**3.30**	3.63	4.00	
Pre-Service Evaluation Time:			**10.0**			
Pre-Service Positioning Time:			**5.0**			

Pre-Service Scrub, Dress, Wait Time:				5.0		
Intra-Service Time:		25.00	40.00	**40.00**	50.00	55 00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**15.0**	99211x **0.0**	12x **1.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2044	010	3.14

CPT Descriptor Layer closure of wounds of neck, hands, feet, and/or external genitalia; 7.6-12.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 42.8 %

TIME ESTIMATES (Median)	CPT Code: 11444	Key Reference CPT Code: 12044
Median Pre-Service Time	20 00	9.00
Median Intra-Service Time	40.00	56.00
Median Immediate Post-service Time	10.00	9 00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15 0	15.00
Median Total Time	**85.00**	**89.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	2.71
Urgency of medical decision making	2.57	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.42
Physical effort required	3.57	3.42

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.85
Outcome depends on the skill and judgment of physician	3.28	3.14
Estimated risk of malpractice suit with poor outcome	2.85	2.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.14	3.00
Intra-Service intensity/complexity	3.86	3.57
Post-Service intensity/complexity	3.00	3.14

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Please see accompanying multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11444

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		50.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 33.0	Staff % of Physician time 66%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		40.0	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 27.0	Staff % of Physician time **Change:** **In Time** 66% -6.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11446 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **4.50**
RUC RVU: **4.48**

CPT Descriptor: Excision, other benign lesion including margins (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous mebmrane; excised diameter over 4.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35 year old presents for removal of a biopsy-provoen atypical pigmented nevus on the left zygomatic area of the cheek with excised diameter of 4.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The benefits, risks and alternatives to removal are explained. The procedure is explained, and the healing period with restrictions is reviewed. Dates for probable suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit. Consent is obtained.

Description of Intra-Service Work: The physician cleanses the area with betadine, and with a sterile surgical marker delineates the extent of the excision. Physician then injects with local anesthetic.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the borders of the lesion. The excision is carried through the dermis into the subcutaneous fat. Hemostasis is achieved with either cautery and/or suture. Undermining as necessary to ease wound tension is performed. The wound is closed in one layer using non absorbable suture. The area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD; James Denneny, III, MD					
Specialty(s):	AAD, ASPS, AAOHNS					
CPT Code:	11446					
Sample Size:	200	**Resp n:** 11		**Response:** 0.00 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	2.50	4.22	**4.50**	4.85	5.00	
Pre-Service Evaluation Time:			**10.0**			
Pre-Service Positioning Time:			**5.0**			
Pre-Service Scrub, Dress, Wait Time:			**5.0**			

Intra-Service Time:		45.00	58.00	**60.00**	63.00	100.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**23.0**	99211x **0.0**	12x **0.0**	13x **1.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2054	010	3.54

CPT Descriptor Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes, 7.6 - 12.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 36.3 %

TIME ESTIMATES (Median)

	CPT Code: 11446	**Key Reference CPT Code: 12054**
Median Pre-Service Time	20.00	12.00
Median Intra-Service Time	60.00	66.00
Median Immediate Post-service Time	10.00	12.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	15.00
Median Total Time	**113.00**	**105.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3 00	3 00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.71
Urgency of medical decision making	3.00	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	4.28	3.71
Physical effort required	4.00	3.71

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.71	2.71
Outcome depends on the skill and judgment of physician	3.85	3.42
Estimated risk of malpractice suit with poor outcome	3.57	2.85

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.20	3.00
Intra-Service intensity/complexity	4.10	3.70
Post-Service intensity/complexity	3 25	3 42

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Please see accompanying multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11446

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		55.00	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 37.0	Staff % of Physician time 68%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 41.0	Staff % of Physician time **Change:** **In Time** 68% 4.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11600 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.6**
RUC RVU: **1.31**

CPT Descriptor: Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.5 cm or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the upper back with excised diameter of 0.45 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access. The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD					
Specialty(s):	AAD					
CPT Code:	11600					
Sample Size:	80	**Resp n:** 7		**Response:** 8.7 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.10	1.43	**1.60**	2.42	3.00

code11600

Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
ıtra-Service Time:	10.00	15.00	**10.00**	22 50	25 00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2001	010	1.70

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 57.1 %

TIME ESTIMATES (Median)	CPT Code: 11600	Key Reference CPT Code: 12001
Median Pre-Service Time	10.00	5.00
Median Intra-Service Time	10.00	18.00
Median Immediate Post-service Time	5 00	5 00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	8.00
Median Total Time	**48.00**	**36.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.14	2.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.43
Urgency of medical decision making	3.14	2.29

Technical Skill/Physical Effort (Mean)

Technical skill required	2.88	3.00
Physical effort required	2.71	2.85

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.29	2.43
Outcome depends on the skill and judgment of physician	3.29	2.43
Estimated risk of malpractice suit with poor outcome	3.29	2 29

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.00
Intra-Service intensity/complexity	3 00	3 00
Post-Service intensity/complexity	3.00	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 14% No 86%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11600

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		17.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 15.0	Staff % of Physician time 88%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		10.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 7.0	Staff % of Physician time **Change: In Time** 88% -8.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11601 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.10**
RUC RVU: **1.75**

CPT Descriptor: Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the upper back with excised diameter of 0.90 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access. The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD				
Specialty(s):	AAD				
CPT Code:	11601				
Sample Size:	80	**Resp n:** 7	**Response:** 8.7 %		
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.80	1.98	**2.10**	2.88	3.60
Pre-Service Evaluation Time:			**15.0**		

Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		15.00	18.00	**20.00**	22.50	24.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**23.0**	99211x **0.0**	12x **0.0**	13x **1.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2001	010	1.70

CPT Descriptor

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1 86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 57.1 %

TIME ESTIMATES (Median)	**CPT Code: 11601**	**Key Reference CPT Code: 12001**
Median Pre-Service Time	15.00	5.00
Median Intra-Service Time	20.00	18.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0 0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	8.00
Median Total Time	**63.00**	**36.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.29	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.88	2.29
Urgency of medical decision making	3.14	2.14

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.88
Physical effort required	2.43	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.14	2.29
Outcome depends on the skill and judgment of physician	3.00	2.29
Estimated risk of malpractice suit with poor outcome	3.14	1.66

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.86	2.43
Intra-Service intensity/complexity	2.86	2.71
Post-Service intensity/complexity	2.86	2.57

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation

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SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 14% No 86%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11601

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		19.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time 89%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		20.0	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 18.0	Staff % of Physician time **Change:** **In Time** 89% 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11602 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.5**
RUC RVU: **1.95**

CPT Descriptor: Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the upper back with excised diameter of 1.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access. The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD					
Specialty(s):	AAD					
CPT Code:	11602					
Sample Size:	80	**Resp n:** 7		**Response:** 8.7 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.10	2.28	**2.50**	3.55	3.80
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		15.00	19.50	**25.00**	32.50	35 00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**23.0**	99211x **0.0**	12x **0.0**	13x **1.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2031	010	2.15

CPT Descriptor Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet), 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 57.1 %

TIME ESTIMATES (Median)	**CPT Code: 11602**	**Key Reference CPT Code: 12031**
Median Pre-Service Time	15.00	6.00
Median Intra-Service Time	25.00	24.00
Median Immediate Post-service Time	5.00	6.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0 0	0 00
Median Discharge Day Management Time	0 0	0.00
Median Office Visit Time	23 0	9.00
Median Total Time	**68.00**	**45.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.14	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.14	2.88
Urgency of medical decision making	3.57	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	3.14	3.14
Physical effort required	3.00	3.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.29	2.88
Outcome depends on the skill and judgment of physician	3.43	2.86
Estimated risk of malpractice suit with poor outcome	3.43	2.57

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.71
Intra-Service intensity/complexity	3.14	3 43
Post-Service intensity/complexity	3.14	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11602

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 22.0	Staff % of Physician time 88%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 22.0	Staff % of Physician time **Change:** **In Time** 88% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11603 | Global Period: 010 | **Recommended Work Relative Value**
Specialty Society RVU. **3.42**
RUC RVU. **2.50**

CPT Descriptor: Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 2.1 to 3.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous call carcinoma on the upper back with excised diameter of 2.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review pre-operative work up, paying special attention to pathology report.
- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient with the idea being to make an elliptical incision around the lesion.
- Indicate area of skin to be prepped and draped.
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take effect.

Description of Intra-Service Work:

Make an elliptical incision around the entire lesion (excisional biopsy) with a 4mm margin of normal skin, 2mm more in all directions than a benign lesion. The dissection should be full thickness and include enough subcutaneous fat to give adequate margins for the malignant skin lesion. This excision of subcutaneous tissue may go down to fascia in order to give a clear margin. Hemostasis should be meticulous and the electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work:

Day of procedure:

- Apply sterile dressings.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Discuss the need for follow-up care to detect recurrent tumor.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms

In office after procedure:

- Review pathology report and confer with pathologist as necessary regarding margins, depth of excision, residual cancer, etc.
- Examine and talk with patient.

- Check wound and remove sutures.
- Answer patient/family questions.
- If necessary, re-educate the patient about the need for follow-up care to detect recurrent lesions.
- Dictate progress notes for medical records, and letter to referring / family physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD					
Specialty(s):	General Surgery, Plastic Surgery, Dermatology					
CPT Code:	11603					
Sample Size:	250	**Resp n:** 87		**Response:** 34.8 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.50	2.50	**3.42**	3.45	6.32
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		15.00	55.00	**30.00**	60.00	60 00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2054	010	3.45

CPT Descriptor Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 22.9 %

TIME ESTIMATES (Median)	**CPT Code: 11603**	**Key Reference CPT Code: 12054**
Median Pre-Service Time	30.00	12.00
Median Intra-Service Time	30.00	66.00
Median Immediate Post-service Time	10.00	12.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	15.00
Median Total Time	**93.00**	**105.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2 50	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.90	2.75
Urgency of medical decision making	3 20	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.95	2.75
Physical effort required	2.50	2.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.20
Outcome depends on the skill and judgment of physician	3.25	3.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.00	2.50
Intra-Service intensity/complexity	3.20	3.00
Post-Service intensity/complexity	2.00	2.20

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Please see attached multi-specialty letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 22% No 78%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11603

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		33.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 29.0	Staff % of Physician time 88%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 27.0	Staff % of Physician time **Change: In Time** 88% -2.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11604 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **3.80**
RUC RVU: **2.85**

CPT Descriptor: Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 3.1 to 4.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous call carcinoma on the upper back with excised diameter of 3.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review pre-operative work up, paying special attention to pathology report.
- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient with the idea being to make an elliptical incision around the lesion.
- Indicate area of skin to be prepped and draped.
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take effect.

Description of Intra-Service Work:
Make an elliptical incision around the entire lesion (excisional biopsy) with a 4mm margin of normal skin, 2mm more in all directions than a benign lesion. The dissection should be full thickness and include enough subcutaneous fat to give adequate margins for the malignant skin lesion. This excision of subcutaneous tissue may go down to fascia in order to give a clear margin. Hemostasis should be meticulous and the electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work:
Day of procedure:
- Apply sterile dressings.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Discuss the need for follow-up care to detect recurrent tumor.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms.

In office after procedure:
- Review pathology report and confer with pathologist as necessary regarding margins, depth of excision, residual cancer, etc.
- Examine and talk with patient.

- Check wound and remove sutures.
- Answer patient/family questions.
- If necessary, re-educate the patient about the need for follow-up care to detect recurrent lesions.
- Dictate progress notes for medical records, and letter to referring / family physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD					
Specialty(s):	General Surgery, Plastic Surgery, Dermatology					
CPT Code:	11604					
Sample Size:	250	**Resp n:** 44		**Response:** 17.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.30	3.78	**3.80**	3.80	5 22
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		15.00	49.00	**40.00**	60.00	65.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
13150	010	3.80

CPT Descriptor Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 40.9 %

TIME ESTIMATES (Median)	**CPT Code: 11604**	**Key Reference CPT Code: 13150**
Median Pre-Service Time	30.00	21.00
Median Intra-Service Time	40.00	39.00
Median Immediate Post-service Time	10.00	21.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	15.00
Median Total Time	**103.00**	**96.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.20	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.40
Urgency of medical decision making	4.00	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.10	4.00
Physical effort required	3.50	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.75
Outcome depends on the skill and judgment of physician	3.75	3.50
Estimated risk of malpractice suit with poor outcome	4.00	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.50	3.20
Intra-Service intensity/complexity	3.75	3.50
Post-Service intensity/complexity	3.10	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Please see attached multi-specialty letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 14% No 86%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11604

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		39.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 34.0	Staff % of Physician time 87%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		40.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 35.0	Staff % of Physician time **Change:** **In Time** 87% 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11606 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU **5.25**
RUC RVU **4.70**

CPT Descriptor: Excision, malignant lesion including margins, trunk, arms, or legs, excised diameter over 4.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous call carcinoma on the upper back with excised diameter of 4.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review pre-operative work up, paying special attention to pathology report.
- Meet with patient to review planned procedure and post-operative management.
- Review and obtain informed consent with patient, including witness.
- Verify that all required instruments and supplies are available.
- Monitor/assist with positioning of patient.
- Mark site and side of proposed skin incision and confirm with patient with the idea being to make an elliptical incision around the lesion.
- Indicate area of skin to be prepped and draped.
- Scrub and gown.
- Perform surgical "time out".
- Administer local anesthetic using a field block technique and wait for it to take effect.

Description of Intra-Service Work:
Make an elliptical incision around the entire lesion (excisional biopsy) with a 4mm margin of normal skin, 2mm more in all directions than a benign lesion. The dissection should be full thickness and include enough subcutaneous fat to give adequate margins for the malignant skin lesion. This excision of subcutaneous tissue may go down to fascia in order to give a clear margin. Hemostasis should be meticulous and the electrocautery is used with attention to not destroying tissue architecture. A suture is placed in the edge of the specimen before it is removed from the body, i.e. at 12 o'clock. The original position of this suture is noted with a drawing on the pathology specimen form. The skin is then closed using interrupted nylon sutures or skin staples.

Description of Post-Service Work:
Day of procedure:

- Apply sterile dressings.
- Discuss procedure, discharge instructions, and outcome with patient.
- Write prescriptions for medications needed post-discharge as needed.
- Discuss the need for follow-up care to detect recurrent tumor.
- Dictate operative report and copy referring physician(s) along with a letter outlining plans for management long term.
- All appropriate medical records are completed, discharge summary and insurance forms.

In office after procedure:

- Review pathology report and confer with pathologist as necessary regarding margins, depth of excision, residual cancer, etc.
- Examine and talk with patient.

- Check wound and remove sutures.
- Answer patient/family questions.
- If necessary, re-educate the patient about the need for follow-up care to detect recurrent lesions.
- Dictate progress notes for medical records, and letter to referring / family physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Charles D. Mabry, MD, FACS, Keith E. Brandt, MD, FACS, James A. Zalla, MD, Bruce Deitchman, MD					
Specialty(s):	General Surgery, Plastic Surgery, Dermatology					
CPT Code:	11606					
Sample Size: 250	**Resp n:** 43		**Response:** 17.2 %			
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	2.60	4.70	**5.25**	5.25	5.94	
Pre-Service Evaluation Time:			**20.0**			
Pre-Service Positioning Time:			**5.0**			
Pre-Service Scrub, Dress, Wait Time:			**5.0**			
Intra-Service Time:	25.00	68.00	**90.00**	90.00	95 00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
12017	010	4.70

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 53.4 %

TIME ESTIMATES (Median)	**CPT Code: 11606**	**Key Reference CPT Code: 12017**
Median Pre-Service Time	30 00	14 00
Median Intra-Service Time	90.00	119.00
Median Immediate Post-service Time	10.00	12.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	15.00
Median Total Time	**153.00**	**160.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	4.20	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.40	4 20
Urgency of medical decision making	5.00	4.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.70	4.50
Physical effort required	4.20	4.50
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	5.20	5 00
Outcome depends on the skill and judgment of physician	4.90	5.00
Estimated risk of malpractice suit with poor outcome	5.20	4.95

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.00	4.00
Intra-Service intensity/complexity	5.10	5.00
Post-Service intensity/complexity	4.30	4.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
See attached multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 21% No 79%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11606

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		51.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 45.0	Staff % of Physician time 88%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 79.0	Staff % of Physician time **Change:** **In Time** 88% 34.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11620 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.78**
RUC RVU: **1.32**

CPT Descriptor: Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the left parietal area of the scalp with excised diameter of 0.45 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD					
Specialty(s):	AAD					
CPT Code:	11620					
Sample Size:	80	**Resp n:** 8		**Response:** 10.0 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.40	1.50	**1.78**	3.43	3.85

Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
ıtra-Service Time:	10.00	15.00	**10.00**	22 00	25 00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2031	010	2.15

CPT Descriptor Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
11200	010	0 77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	**CPT Code: 11620**	**Key Reference CPT Code: 12031**
Median Pre-Service Time	10.00	6.00
Median Intra-Service Time	10.00	24.00
Median Immediate Post-service Time	5.00	6.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	9.00
Median Total Time	**48.00**	**45.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	2.50
Urgency of medical decision making	3.00	2.88

Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	3.13
Physical effort required	2.88	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.75	3.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	2.88	2.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	3.00
Intra-Service intensity/complexity	3.25	3.25
Post-Service intensity/complexity	2.88	2.75

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11620

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		20.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 18.0	Staff % of Physician time 90%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		10.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 9.0	Staff % of Physician time **Change:** **In Time** 90% -9.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11621 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.13**
RUC RVU: **1.76**

CPT Descriptor: Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the left parietal area of the scalp with excised diameter of 0.90 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access. The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A Zalla, MD, Bruce Deitchman, MD and James Denney III, MD					
Specialty(s):	AAD AAO-HNS					
CPT Code:	11621					
Sample Size:	110	**Resp n:** 10		**Response:** 9.0 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.80	2.00	**2.13**	3.19	4 00

Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
ıtra-Service Time:	15.00	16.25	**20.00**	28.75	30.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2031	010	2.15

CPT Descriptor Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1 86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	**CPT Code: 11621**	**Key Reference CPT Code: 12031**
Median Pre-Service Time	15.00	6.00
Median Intra-Service Time	20.00	24.00
Median Immediate Post-service Time	5 00	6 00
Median Critical Care Time	0.0	0 00
Median Other Hospital Visit Time	0.0	0 00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	9.00
Median Total Time	**63.00**	**45.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.11	2.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.44
Urgency of medical decision making	3.00	2.89

Technical Skill/Physical Effort (Mean)

Technical skill required	3.33	3 22
Physical effort required	3.11	3 11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.89	2.89
Outcome depends on the skill and judgment of physician	2 89	2.89
Estimated risk of malpractice suit with poor outcome	2.89	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.89
Intra-Service intensity/complexity	3.11	3.22
Post-Service intensity/complexity	2.78	2.66

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), and the American Association of Otolaryngologists-Head and Neck Surgeons (AAO-HNS) have surveyed this code using one or more panels of members within their respective organizations. The data collected has been reviewed by each society's respective RBRVS committees and is presented here as a joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11621

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		21.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 18.0	Staff % of Physician time 86%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		20.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time **Change: In Time** 86% -1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.0	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11622 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.7**
RUC RVU: **2.09**

CPT Descriptor: Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the left parietal area of the scalp with excised diameter of 1.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A. Zalla MD Bruce Deitchman MD					
Specialty(s):	AAD					
CPT Code:	11622					
Sample Size:	80	**Resp n:** 8		**Response:** 10.0 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.25	2.38	**2.70**	3.88	4.25

Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
ıtra-Service Time:	20.00	27.50	**25.00**	37.50	45.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2031	010	2.15

CPT Descriptor Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet), 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	CPT Code: 11622	Key Reference CPT Code: 12031
Median Pre-Service Time	15.00	6.00
Median Intra-Service Time	25.00	24.00
Median Immediate Post-service Time	5 00	6.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	9.00
Median Total Time	**68.00**	**45.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3 14	3 14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	2.88
Urgency of medical decision making	3.57	3.14

Technical Skill/Physical Effort (Mean)

Technical skill required	3.29	3.43
Physical effort required	3.14	3.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	3.00
Outcome depends on the skill and judgment of physician	3.71	3.14
Estimated risk of malpractice suit with poor outcome	3.57	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.14	3.14
Intra-Service intensity/complexity	3.57	3.71
Post-Service intensity/complexity	3.00	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11622

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		31.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 27.0	Staff % of Physician time 87%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 22.0	Staff % of Physician time **Change:** **In Time** 87% -5.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11623 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU· **3.06**
RUC RVU. **2.79**

CPT Descriptor: Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia, excised diameter 2 1 to 3.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous call carcinoma on the left parietal area of the scalp with excised diameter of 1.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 13%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: The patient is placed on the surgical table and positioned for access. The area is cleansed with betadine, a sterile surgical marker is used to delineate the extent of the planned excision. Lidocaine is injected.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat.. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD; James Denneny, III, MD					
Specialty(s):	AAD, ASPS, AAOHNS					
CPT Code:	11623					
Sample Size:	200	**Resp n:** 60		**Response:** 0.00 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	2.00	2.79	**3.06**	4.21	7.00	

Pre-Service Evaluation Time:			**20.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
ıtra-Service Time:	10.00	25.00	**30.00**	45.00	90.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2031	010	2.15

CPT Descriptor Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 15.0 %

TIME ESTIMATES (Median)	CPT Code: 11623	Key Reference CPT Code: 12031
Median Pre-Service Time	30.00	26.00
Median Intra-Service Time	30 00	57.00
Median Immediate Post-service Time	10 00	25 00
Median Critical Care Time	0 0	0 00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	15 00
Median Total Time	**93.00**	**123.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.80	2.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.66	1.94
Urgency of medical decision making	2.54	2.12
Technical Skill/Physical Effort (Mean)		
Technical skill required	2 91	2.55
Physical effort required	2.54	2.30
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.89	2.24
Outcome depends on the skill and judgment of physician	3.00	2.36
Estimated risk of malpractice suit with poor outcome	2.89	2.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.80	2.27
Intra-Service intensity/complexity	2.97	2 42
Post-Service intensity/complexity	2.57	2.03

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Please see accompanying multi-specialty letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11623

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		36.00	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 32.0	Staff % of Physician time 89%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 27.0	Staff % of Physician time **Change:** **In Time** 89% -5.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11624 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **3.48**
RUC RVU: **3.30**

CPT Descriptor: Excision,, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous call carcinoma on the left parietal area of the scalp with excised diameter fo 3.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 15%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: The patient is placed on the surgical table and positioned for access. The area is cleansed with betadine, a sterile surgical marker is used to delineate the extent of the planned excision. Lidocaine is injected.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat.. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD					
Specialty(s):	AAD, ASPS					
CPT Code:	11624					
Sample Size:	200	**Resp n:** 39		**Response:** 0.00 %		
ample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.50	2.86	**3.48**	4.21	6.98
Pre-Service Evaluation Time:				**20.0**		

Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		25.00	29.00	**40.00**	45.00	55.00
ost-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**23.0**	99211x **0.0**	12x **0.0**	13x **1.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3132	010	5.94

CPT Descriptor Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet· 2 6 to 7 5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 20.5 %

TIME ESTIMATES (Median)	CPT Code: 11624	Key Reference CPT Code: 13132
Median Pre-Service Time	30.00	30.00
Median Intra-Service Time	40.00	45.00
Median Immediate Post-service Time	10.00	11.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	46.00
Median Total Time	**103.00**	**132.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.66	3.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.66	2.50
Urgency of medical decision making	4.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.66
Physical effort required	3.66	3.66

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.83	3.16
Outcome depends on the skill and judgment of physician	4.00	3.16
Estimated risk of malpractice suit with poor outcome	3.83	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.80	3.00
Intra-Service intensity/complexity	3.70	3.70
Post-Service intensity/complexity	3.00	2.80

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Please see accompanying mutli-specialty cover letter

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11624

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		41.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 36.0	Staff % of Physician time 88%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213.	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		40.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 36.0	Staff % of Physician time **Change:** **In Time** 88% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 11626 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **4.90**
RUC RVU: **4.29**

CPT Descriptor: Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter over 4.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous call carcinoma on the left parietal area of the scalp with excisded diameter of 4.6 cm

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: The patient is placed on the surgical table and positioned for access. The area is leansed with betadine, a sterile surgical marker is used to delineate the extent of the planned excision. Lidocaine is injected.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat.. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD; James Denneny, III, MD				
Specialty(s):	AAD, ASPS, AAOHNS				
CPT Code:	11626				
Sample Size: 200	**Resp n:** 40	**Response:** 0.00 %			
ample Type: Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	3.90	4.50	**4.90**	5.94	8.25
Pre-Service Evaluation Time:			**20.0**		

Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
Intra-Service Time:	30.00	40.00	**60.00**	60 00	140 00

ost-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3151	010	4.44

CPT Descriptor Repair, complex, eyelids, nose, ears, and/or lips; 1.1-2.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 15.0 %

TIME ESTIMATES (Median)	**CPT Code: 11626**	**Key Reference CPT Code: 13151**
Median Pre-Service Time	30.00	26 00
Median Intra-Service Time	60.00	57 00
Median Immediate Post-service Time	10.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0 0	0.00
Median Office Visit Time	23.0	15.00
Median Total Time	**123.00**	**123.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.16
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	2.50
Urgency of medical decision making	4.00	3.16

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.83
Physical effort required	4.00	3.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.16	3.33
Outcome depends on the skill and judgment of physician	4.33	3.33
Estimated risk of malpractice suit with poor outcome	4.00	3.16

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.00	3.20
Intra-Service intensity/complexity	4.30	3.70
Post-Service intensity/complexity	3.30	2.80

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Please see accompanying multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 3% No 97%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11626

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.00	
Clinical Staff #1	Staff Type: RN/LPM/MTA	Intra Assist Physician Time: 40.0	Staff % of Physician time 89%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 1.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 54.0	Staff % of Physician time **Change: In Time** 89% 14.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11640 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.85**
RUC RVU: **1.35**

CPT Descriptor: Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the left zygomatic area of the cheek with excised diameter of 0.45 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access. The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A Zalla, MD, Bruce Deitchman, MD and James Denney III, MD				
Specialty(s):	AAD AAO-HNSF				
CPT Code:	11640				
ample Size: 80	**Resp n:** 8	**Response:** 10.0 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**

code11640

Survey RVW:		1.50	1.67	**1.85**	2.52	4.00
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**0.0**		
re-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	19.00	**10.00**	22.50	25.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**23.0**	99211x **0.0**	12x **0.0**	13x **1.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2011	010	1.76

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 62.5 %

TIME ESTIMATES (Median)	**CPT Code: 11640**	**Key Reference CPT Code: 12011**
Median Pre-Service Time	10.00	6.00
Median Intra-Service Time	10.00	22.00
Median Immediate Post-service Time	5.00	6.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	9.00
Median Total Time	**48.00**	**43.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.13	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 00	2 50
Urgency of medical decision making	3.13	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.13
Physical effort required	3.00	2.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.38	2.88
Outcome depends on the skill and judgment of physician	3.38	3.00
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	3.00
Intra-Service intensity/complexity	3.13	3.00
Post-Service intensity/complexity	2.63	2.75

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), and the American Association of Otolaryngologists-Head and Neck Surgeons (AAO-HNS) have surveyed this code using one or more panels of members within their respective organizations. The data collected has been reviewed by each society's respective RBRVS committees and is presented here as a joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 100%

(Use the subset of the people who responded "Yes" to answer the following questions)

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11640

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		15.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 13.0	Staff % of Physician time 87%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		10.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 9.0	Staff % of Physician time **Change:** **In Time** 87% -4.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11641 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **2.5**
RUC RVU: **1.85**

CPT Descriptor: Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the left zygomatic area of the cheek with excised diameter of 0.90 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed A fresh history of medications taken including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access. The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A Zalla, MD and Bruce Deitchman, MD				
Specialty(s):	AAD				
CPT Code:	11641				
ample Size: 80	**Resp n:** 9	**Response:** 11.2 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**

code11641

Survey RVW:		2.10	2.45	**2.50**	2.75	4.12
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
re-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		15.00	22.00	**20.00**	30.00	40 00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**23.0**	99211x **0.0**	12x **0.0**	13x **1.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23), 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2051	010	2.47

CPT Descriptor Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 44.4 %

TIME ESTIMATES (Median)	**CPT Code: 11641**	**Key Reference CPT Code: 12051**
Median Pre-Service Time	15.00	8.00
Median Intra-Service Time	20.00	24.00
Median Immediate Post-service Time	5.00	8 00
Median Critical Care Time	0.0	0 00
Median Other Hospital Visit Time	0 0	0 00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	10.00
Median Total Time	**63.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.22	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	2.66
Urgency of medical decision making	3.22	3.11

Technical Skill/Physical Effort (Mean)

Technical skill required	3.55	3.33
Physical effort required	3.00	3.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	2.88
Outcome depends on the skill and judgment of physician	3.22	3.11
Estimated risk of malpractice suit with poor outcome	3.11	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 38	3.00
Intra-Service intensity/complexity	3.25	3 22
Post-Service intensity/complexity	2 88	2.66

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 22% No 88%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11641

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 22.0	Staff % of Physician time 88%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		20.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 18.0	Staff % of Physician time **Change: In Time** 88% -4.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11642 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU. **2.5**
RUC RVU: **2.30**

CPT Descriptor: Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male presents for removal of a biopsy-proven squamous cell carcinoma on the left zygomatic area of the cheek with excised diameter of 1.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre Service: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: Intra Service: The patient is placed on the surgical table and positioned for access. The area is cleansed with dermalogical surgery scrub; a sterile surgical marker is used to delineate the extent of the planned excision including appropriate margins. Lidocaine is injected.
The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. The wound is closed with suture material. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Post service: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A Zalla, MD, Bruce Deitchman, MD and James Denney III, MD					
Specialty(s):	AAD AAO-HNS					
CPT Code:	11642					
Sample Size:	115	**Resp n:** 11		**Response:** 9.5 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.10	2 45	**2.50**	2.75	4 12

Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
ıtra-Service Time:	15.00	22.00	**25.00**	30.00	40.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2051	010	2.47

CPT Descriptor Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11200	010	0.77

CPT Descriptor 1 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

MPC CPT Code 2	Global	Work RVU
11750	010	1.86

CPT Descriptor 2 Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal;

Other Reference CPT Code	Global	Work RVU
	010	

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 45.4 %

TIME ESTIMATES (Median)	**CPT Code: 11642**	**Key Reference CPT Code: 12051**
Median Pre-Service Time	15.00	8.00
Median Intra-Service Time	25.00	24.00
Median Immediate Post-service Time	5.00	8.00
Median Critical Care Time	0 0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	10.00
Median Total Time	**68.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	2.75
Urgency of medical decision making	3.00	2.63

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3 38
Physical effort required	3.00	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	3.13
Outcome depends on the skill and judgment of physician	3.38	3.00
Estimated risk of malpractice suit with poor outcome	3.25	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.38	3.13
Intra-Service intensity/complexity	3.50	3.50
Post-Service intensity/complexity	3.00	2.88

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), and the American Association of Otolaryngologists-Head and Neck Surgeons (AAO-HNS) have surveyed this code using one or more panels of members within their respective organizations. The data collected has been reviewed by each society's respective RBRVS committees and is presented here as a joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 9% No 91%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11642

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		38.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 33.0	Staff % of Physician time 87%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 22.0	Staff % of Physician time **Change:** **In Time** 87% -11 0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time.	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11643 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **3.6**
RUC RVU: **3.1**

CPT Descriptor: Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male present for removal of a biopsy-proven squamous cell carcinoma on the left zygomatic area of the cheek with excised diameter of 2.6 cm

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 14%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: The patient is placed on the surgical table and positioned for access. The area is cleansed with betadine, a sterile surgical marker is used to delineate the extent of the planned excision. Lidocaine is injected.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat.. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD					
Specialty(s):	AAD, ASPS					
CPT Code:	11643					
Sample Size:	200	**Resp n:** 55		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.10	3.27	**3.60**	5.13	9.00
Pre-Service Evaluation Time:				**20.0**		

Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		13.00	30.00	**30.00**	58 00	90.00

ost-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3152	010	6.32

CPT Descriptor Repair, complex, eyelids, nose, ears, and/or lips; 2.6 to 7.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 25.4 %

TIME ESTIMATES (Median)	**CPT Code: 11643**	**Key Reference CPT Code: 13152**
Median Pre-Service Time	30.00	26.00
Median Intra-Service Time	30.00	73.00
Median Immediate Post-service Time	10.00	26.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	15 00
Median Total Time	**93.00**	**140.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.17	2.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.94	2.17
Urgency of medical decision making	2.77	2.34

Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	2.77
Physical effort required	2.83	2.51

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.43	2.40
Outcome depends on the skill and judgment of physician	3.40	2.69
Estimated risk of malpractice suit with poor outcome	3.51	2.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.14	2.49
Intra-Service intensity/complexity	3.26	2 74
Post-Service intensity/complexity	2.91	2.20

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Please see accompany multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11643

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		47.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 41.0	Staff % of Physician time 87%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 27.0	Staff % of Physician time **Change: In Time** 87% -14.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11644 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **4.61**
RUC RVU: **4.02**

CPT Descriptor: Excision, malignant lesion including margins, face, ears, eyelids, nose, lips, excised diameter 3.1 to 4.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male present for removal of a biopsy-proven squamous cell carcinoma on the left zygomatic area of the cheek with excised diameter of 2.6 cm.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: The patient is placed on the surgical table and positioned for access. The area is cleansed with betadine, a sterile surgical marker is used to delineate the extent of the planned excision. Lidocaine is injected.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat.. With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. Area is cleansed, dried and pressure bandage is applied.

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD; James Denneny, III, MD					
Specialty(s):	AAD, ASPS, AAOHNS					
CPT Code:	11644					
Sample Size:	200	**Resp n:** 41		**Response:** 0 00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.50	4.50	**4.61**	4.86	6 50

Pre-Service Evaluation Time:			**20.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
ıtra-Service Time:	40.00	46.00	**45.00**	60.00	120.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3132	010	5.94

CPT Descriptor Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 to 7.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 29.2 %

TIME ESTIMATES (Median)	CPT Code: 11644	Key Reference CPT Code: 13132
Median Pre-Service Time	30.00	30 00
Median Intra-Service Time	45.00	45 00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	46.00
Median Total Time	**108.00**	**136.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.42	3 28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 42	3 14
Urgency of medical decision making	3.71	3.42

Technical Skill/Physical Effort (Mean)

Technical skill required	4.14	4.28
Physical effort required	3.85	4.28

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3 85
Outcome depends on the skill and judgment of physician	4.14	4 00
Estimated risk of malpractice suit with poor outcome	4.00	3.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.40	3.70
Intra-Service intensity/complexity	3.90	4.00
Post-Service intensity/complexity	3.70	3.60

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Please see accompanying multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11644

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		57.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 50.0	Staff % of Physician time 88%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		45.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 40.0	Staff % of Physician time **Change:** **In Time** 88% -10.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:11646 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **6.30**
RUC RVU: **5.94**

CPT Descriptor: Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old male present for removal of a biopsy-proven squamous cell carcinoma on the left zygomatic area of the cheek with excised diameter of 4.6 cm

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The patient is taken to the surgical room, and gowned. The benefits, risks and alternatives to removal are explained. Sun exposure discussed. The procedure is explained, and the healing period with restrictions is reviewed. Probable dates for suture removal are discussed. A fresh history of medications taken, including aspirin, vitamin E, and/or other blood thinners is reviewed along with a review of pertinent problems that may have arisen since the scheduling visit.

Description of Intra-Service Work: The patient is placed on the surgical table and positioned for access. The area is cleansed with betadine, a sterile surgical marker is used to delineate the extent of the planned excision. Lidocaine is injected.

The patient is re-prepped and draped, lights are positioned, and a scalpel is used to incise along the planned borders of the excision. The excision is carried through the dermis into and through the subcutaneous fat . With manual and visual inspection the specimen and wound margin are examined to ascertain that no clinically visible or palpable tumor is left behind. The specimen is then oriented and marked with sutures to facilitate the report of accurate margins by the pathology laboratory. Hemostasis is achieved with either cautery and/or suture. Suture material is used to close the wound. Area is cleansed, dried and pressure bandage is applied

Description of Post-Service Work: Wound care is reviewed, instructions for problems such as bleeding, pain or dehiscence, restrictions on motion and activities reviewed. Prescriptions for pain and antibiotics, if needed, are given.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Siegel, MD; Keith Brandt, MD					
Specialty(s):	AAD, ASPS					
CPT Code:	11646					
Sample Size:	200	**Resp n:** 39		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		5.00	5.85	**6.30**	6.50	7.50

Pre-Service Evaluation Time:			**20.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
ıtra-Service Time:	50.00	59.00	**65.00**	66.00	120.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3132	010	5.94

CPT Descriptor Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6-7.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 23.0 %

TIME ESTIMATES (Median)	CPT Code: 11646	Key Reference CPT Code: 13132
Median Pre-Service Time	30.00	30.00
Median Intra-Service Time	65.00	45.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	23.0	46.00
Median Total Time	**128.00**	**136.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.14
Urgency of medical decision making	3.85	3.42

Technical Skill/Physical Effort (Mean)

Technical skill required	4.28	4.00
Physical effort required	4.14	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.28	3.85
Outcome depends on the skill and judgment of physician	4.28	3.85
Estimated risk of malpractice suit with poor outcome	4.00	3.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.14	3.90
Intra-Service intensity/complexity	4.30	4.10
Post-Service intensity/complexity	4.00	3.70

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
Please see accompany multi-specialty cover letter.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 11646

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		62.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 55.0	Staff % of Physician time 89%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 1.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		65.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 57.0	Staff % of Physician time **Change:** **In Time** 89% 2.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:12052 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **3.2**
RUC RVU: **2.77**

CPT Descriptor: Layer closure of wounds of face, ears, eyelids, nose, lips and or mucous membranes; 2.6 to 5.0 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old male requires closure of a surgical wound of the lower left cheek resulting in a defect measuring 2.4 x 0.8 cm. The defect extends to subcutaneous tissue with a large subcutaneous dead space. The wound is under significant tension.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work begins with assessing the patient taking a history; reviewing current prescriptions, obtaining and reviewing current 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 preoperative services include dressing, scrubbing; supervising the positioning, prepping and draping of the patient and ensuring that the necessary surgical instruments and supplies are present.

Description of Intra-Service Work: Injection of local anesthetic for anesthesia and hemostasis. Waiting for adequate anesthesia. Appropriate prepping and draping of the area. Closure of the defect may require; additional removal of wound debris, irrigation, and electrocauterization for hemostasis. Sutures are placed in the superfiscial fascia to close the dead space and approximate the tissues. Suturing of the skin is performed as a separate layer. The area is cleansed and a sterile dressing is applied.

Description of Post-Service Work: Post-service work begins with monitoring patient stabilization post procedure. Operative report is dictated and orders are written. The physician communicates with the family and other health care professionals (including written and oral reports). Discharge management includes; the surgeon's final examination of the patient, discussion of home care and follow up. Completion of discharge forms and prescriptions. Reconciliation of pre-procedure prescriptions. Communication with other health care providers and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005		
Presenter(s):	James A. Zalla, MD Keith Brandt, MD James Denneny III, MD		
Specialty(s):	AAD, ASPS, AAO-HNS		
CPT Code:	12052		
Sample Size:	313	**Resp n:** 43	**Response:** 13.7 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	2.40	2.84	**3.20**	3.80	6.00
Pre-Service Evaluation Time:			**5.0**		

Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	20.00	24.50	**28.00**	30.00	80.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**30.0**	99211x **0.0** 12x **2.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3131	010	3.78

CPT Descriptor Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
12051	010	2.47

CPT Descriptor 1 Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less

MPC CPT Code 2	Global	Work RVU
20103	010	5.29

CPT Descriptor 2 Exploration of penetrating wound (separate procedure); extremity

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 44 1 %

TIME ESTIMATES (Median)	CPT Code: 12052	Key Reference CPT Code: 13131
Median Pre-Service Time	5.00	19.00
Median Intra-Service Time	28.00	43.00
Median Immediate Post-service Time	10.00	19.00
Median Critical Care Time	0 0	0 00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	30.0	12.00
Median Total Time	**73.00**	**93.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	3.40	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	3.90	3 80
Physical effort required	3.60	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.70	3.60
Outcome depends on the skill and judgment of physician	4.00	3.90
Estimated risk of malpractice suit with poor outcome	3.60	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.36	3 25
Intra-Service intensity/complexity	3.90	3.80
Post-Service intensity/complexity	3.40	3.20

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), the merican Society of Plastic Surgeons (ASPS) and the American Association of Otolaryngologists-Head and Neck Surgeons (AAO-HNS) have surveyed this code using one or more panels of members within their respective organizations. The data collected has been reviewed by each society's respective RBRVS committees and is presented here as a joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 22% No 88%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 12052

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		26.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		28.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 18.0	Staff % of Physician time **Change:** **In Time** 67% 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 0.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code: 13121 Global Period: 010 Specialty Society RVU: **4.56**

RUC RVU: **4.32**

CPT Descriptor: Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: After excision of a basal cell carcinoma through the dermis and subcutaneous plane on the left anterior pretibial area of a 70 year old diabetic male, a defect requires extensive undermining to allow primary closure.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work begins with assessing the patient taking a history; reviewing current prescriptions, obtaining and reviewing current 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 preoperative services include dressing, scrubbing, supervising the positioning, prepping and draping of the patient and ensuring that the necessary surgical instruments and supplies are present.

Description of Intra-Service Work: Injection of local anesthetic for anesthesia and hemostasis. Waiting for adequate nesthesia. Appropriate prepping and draping of the area. Closure of the wound may require; additional removal of wound debris, irrigation, trimming of ragged skin edges or devitalized tissue, ligation of vessels, electrocauterization for hemostasis, undermining, layered closure and stents. The area is cleansed and a sterile dressing is applied.

Description of Post-Service Work: Post-service work begins with monitoring patient stabilization post procedure. Operative report is dictated and orders are written. The physician communicates with the family and other health care professionals (including written and oral reports). Discharge management includes; the surgeon's final examination of the patient, discussion of home care and follow up. Completion of discharge forms and prescriptions. Reconciliation of pre-procedure prescriptions. Communication with other health care providers and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A. Zalla, MD Keith Brandt, MD James Denneny III, MD Bruce Deitchman, MD				
Specialty(s):	AAD ASPS AAO-HNS				
CPT Code:	13121				
Sample Size: 313	**Resp n:** 45	**Response:** 14.3 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
urvey RVW:	3.30	4.25	**4.30**	5.00	5.90
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		

CPT Code:

Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		35.00	45.00	**60.00**	62.50	75.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**15.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**30.0**	99211x **0.0**	12x **2.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3101	010	3.91

CPT Descriptor Repair, complex, trunk; 2.6 cm to 7.5 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
20103	010	5.09

CPT Descriptor 1 Exploration of penetrating wound (separate procedure); extremity

MPC CPT Code 2	Global	Work RVU
65855	010	3.84

CPT Descriptor 2 Trabeculoplasty by laser surgery, one or more sessions (defined treatment series

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 44.4 %

TIME ESTIMATES (Median)	**CPT Code: 13121**	**Key Reference CPT Code: 13101**
Median Pre-Service Time	10.00	22.00
Median Intra-Service Time	60.00	57.00
Median Immediate Post-service Time	15.00	22.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	30.0	13.00
Median Total Time	**115.00**	**114.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.77	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.20
Urgency of medical decision making	3.59	3.77

Technical Skill/Physical Effort (Mean)

Technical skill required	4.28	4.08
Physical effort required	4.18	3.95

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.18	3.72
Outcome depends on the skill and judgment of physician	4.28	4.05
Estimated risk of malpractice suit with poor outcome	3.79	3.64

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.72	3.56
Intra-Service intensity/complexity	4.31	4.03
Post-Service intensity/complexity	3.51	3.36

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), the merican Society of Plastic Surgeons (ASPS) and the American Association of Otolaryngologists-Heand and Neck Surgeons (AAO-HNS) have surveyed this code using one or more panels of members within their respective organizations. The data collected has been reviewed by each society's respective RBRVS committees and is presented here as a joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 26% No 74%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
I agree 10% I do not agree 90%

B. Patients requiring this service are now:
more complex (more work) 100% less complex (less work) no change

C. The usual site-of-service has changed:
from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 13121

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		57.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 38.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations;use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 40.0	Staff % of Physician time **Change:** **In Time** 67% 2.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code: 14040 Global Period: 010 Specialty Society RVU: **8.55**

RUC RVU: **7.86**

CPT Descriptor: Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old male with an excised basal cell carcinoma on the left medial cheek leaves a defect through the subcutaneous plane that is 1.4 cm diameter and involves the lower part of the left lower eyelid. In order to prevent ectropion, reconstruction via adjacent tissue transfer is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work begins with assessing the patient taking a history; reviewing current prescriptions, obtaining and reviewing current 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 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: Skin markings are made outlining the excision of the lesion and the appropriate margin. Local anesthetic is injected. After an adequate hemostatic wait the lesion is excised. The lesion is oriented and marked with sutures. Hemostasis is obtained. Care is taken to determine the availability of adjacent tissue for closure and the possibility of functional impairment or anatomic distortion of adjacent structures. An adjacent flap is designed. The flap is incised and raised at the apprpriate level. The flap is rotated into the defect. Tension is assessed and additional dissection performed as necessary. Drains may be placed. The flap is sutured into position. A sterile dressing is applied.

Description of Post-Service Work: Post-service work begins with monitoring patient stabilization in the operating and recovery room. Operative report is dictated and orders are written. The physician communicates with the family and other health care professionals (including written and oral reports). Discharge management includes; the surgeon's final examination of the patient, discussion of home care and follow up. Completion of discharge forms and prescriptions. Reconciliation of pre-procedure prescriptions. Communication with other health care providers and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A. Zalla, MD Bruce Deitchman, MD Keith Brandt, MD				
Specialty(s):	AAD ASPS AAO-HNS				
CPT Code:	14040				
ample Size: 356	**Resp n:** 33	**Response:** 9.2 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**

CPT Code:

Survey RVW:		6.50	7.92	**8.55**	9.87	12.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**10.0**		
re-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		50.00	66.25	**90.00**	112.50	120.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**25.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**76.0**	99211x **0.0**	12x **2.0**	13x **2.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41), 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
5260	090	10.04

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
44950	090	9.99

CPT Descriptor 1 Appendectomy

MPC CPT Code 2	Global	Work RVU
46262	090	7.49

CPT Descriptor 2 Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy; with or without fissurectomy

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 63.6 %

TIME ESTIMATES (Median)	CPT Code: 14040	Key Reference CPT Code: 15260
Median Pre-Service Time	30.00	47.00
Median Intra-Service Time	90 00	92.00
Median Immediate Post-service Time	25.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	76.0	67.00
Median Total Time	**221.00**	**236.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.19	4.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.58	3.50
Urgency of medical decision making	3.96	3.77

Technical Skill/Physical Effort (Mean)

Technical skill required	4.77	4.50
Physical effort required	4.31	4.15

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.46	4.23
Outcome depends on the skill and judgment of physician	4.69	4.42
Estimated risk of malpractice suit with poor outcome	4.42	4.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.12	4.04
Intra-Service intensity/complexity	4.65	4 42
Post-Service intensity/complexity	3.96	3.88

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), the merican Society of Plastic Surgeons (ASPS) and the American Association of Otolaryngologists-Heand and Neck Surgeons (AAO-HNS) have surveyed this code using one or more panels of members within their respective organizations. The data collected has been reviewed by each society's respective RBRVS committees and is presented here as a joint recommendation.

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 27% No 73%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 80% less complex (less work) no change 20%
C. The usual site-of-service has changed:
   from outpatient to inpatient 10% from inpatient to outpatient no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 14040

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		92.00	
Clinical Staff #1	Staff Type: rn/lpn/mta	Intra Assist Physician Time: 92.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; usecurrent staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		90.0	
Clinical Staff #1	Staff Type: rn/lpn/mta	Intra Assist Physician Time: 90.0	Staff % of Physician time **Change:** **In Time** 100% -2.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code: 14060 Global Period: 010 Specialty Society RVU: **9.1**

RUC RVU: **8.49**

CPT Descriptor: Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old male with an excised basal cell carcinoma on the lower left lateral sidewall of the nose leaves a defect through the subcutaneous plane that is 1.4 cm diameter and involves the lower part of the left lower eyelid. In order to prevent ectropion, reconstruction via adjacent tissue transfer is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work begins with assessing the patient taking a history; reviewing current prescriptions, obtaining and reviewing current 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 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: Skin markings are made outlining the excision of the lesion and the appropriate margin. Local anesthetic is injected. After an adequate hemostatic wait the lesion is excised The lesion is oriented and marked with sutures. Hemostasis is obtained. Care is taken to determine the availability of adjacent tissue for closure and the possibility of functional impairment or anatomic distortion of adjacent structures. An adjacent flap is designed. The flap is incised and raised at the apprpriate level. The flap is rotated into the defect. Tension is assessed and additional dissection performed as necessary. Drains may be placed. The flap is sutured into position. A sterile dressing is applied.

Description of Post-Service Work: Post-service work begins with monitoring patient stabilization in the operating and recovery room. Operative report is dictated and orders are written. The physician communicates with the family and other health care professionals (including written and oral reports). Discharge management includes; the surgeon's final examination of the patient, discussion of home care and follow up. Completion of discharge forms and prescriptions. Reconciliation of pre-procedure prescriptions. Communication with other health care providers and family

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A. Zalla, MD Bruce Deitchman, MD Keith Brandt, MD James					
Specialty(s):	AAD ASPS AAO-HNS					
CPT Code:	14060					
Sample Size:	351	**Resp n:** 32		**Response:** 9 1 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		7.00	8.50	**9.10**	10.05	13.00

CPT Code:

Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
ntra-Service Time:	35.00	45.00	**60.00**	75.00	120.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**76.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
5260	090	10.04

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips, 20 sq cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
44950	090	9.99

CPT Descriptor 1 Appendectomy

MPC CPT Code 2	Global	Work RVU
46262	090	7.49

CPT Descriptor 2 Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy; with or without fissurectomy

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 65.6 %

TIME ESTIMATES (Median)	**CPT Code: 14060**	**Key Reference CPT Code: 15260**
Median Pre-Service Time	30.00	47.00
Median Intra-Service Time	60.00	92.00
Median Immediate Post-service Time	15.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	76.0	67.00
Median Total Time	**181.00**	**236.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.44	4.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.88
Urgency of medical decision making	4.12	3.92

Technical Skill/Physical Effort (Mean)

Technical skill required	4.92	4.68
Physical effort required	4.60	4.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.60	4 40
Outcome depends on the skill and judgment of physician	4.72	4.52
Estimated risk of malpractice suit with poor outcome	4.64	4.28

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.40	4.20
Intra-Service intensity/complexity	4.84	4.64
Post-Service intensity/complexity	4.28	4.16

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), the merican Society of Plastic Surgeons (ASPS) and the American Association of Otolaryngologists-Head and Neck Surgeons (AAO-HNS) have surveyed this code using one or more panels of members within their respective organizations. The data collected has been reviewed by each society's respective RBRVS committees and is presented here as a joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 21% No 79%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 14% I do not agree 86%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 14060

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.00	
Clinical Staff #1	Staff Type: rn lpn mta	Intra Assist Physician Time: 60.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 5.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations;use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: rn lpn mta	Intra Assist Physician Time: 60.0	Staff % of Physician time **Change:** **In Time** 100% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:15100 | Global Period: 090 | **Recommended Work Relative Value** Specialty Society RVU: **9.00** RUC RVU: **9.04**

CPT Descriptor: : Split graft, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children (except 15050)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male sustains a scald burn to his forearm. After initial treatment with topical antibiotics and dressing changes, an 8 X 10 cm area of full thickness skin loss remains. He is taken to the operating room for burn eschar debridement and coverage. A split-thickness skin graft is harvested from the thigh using a dermatome It is meshed, placed on the wound bed, and secured with sutures around the perimeter and covered with a bolster dressing The donor site is treated with an occlusive dressing. The eschar debridement is reported separately with a different CPT code.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 6%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Preoperative work includes an interval history and physical exam; reviewing the previous work-up and preoperative laboratory test results; 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 type & crossmatch for blood to be administered during the procedure, the administration of preoperative antibiotics, 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 the induction of anesthesia, a split-thickness skin graft 0.008 – 0.016 inches in depth is harvested using a dermatome. A total of 100 sq cm is recovered and is meshed for expansion prior to placement on the excised wound. Hemostasis of the graft site is obtained with epinephrine soaked gauze pads and/or topical thrombin. The skin graft is then applied to the trunk and secured to the excised wound with interrupted sutures, surgical staples, and/or fibrin sealant. A dressing is applied to the graft site and secured to prevent mechanical shear. A dressing is applied to the donor site and covered with dry gauze

Description of Post-Service Work: Postoperative work begins after the application of the wound dressing in the operating room and 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 in the ICU or on a suitable nursing floor. Discharge management include the surgeon's final examination of the patient, instructions for continuing care of the operative sites, 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, dressing changes, and antibiotic and pain medication adjustments.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005
Presenter(s):	Keith Brandt, MD; Scott Oates, MD

Specialty(s):	ASPS		
CPT Code:	15100		
Sample Size:	175	**Resp n:** 32	**Response:** 0 00 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	4.00	9.00	**10.25**	13.25	21 00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	20.00	45.00	**60.00**	71.00	90.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**20.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**19.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**76.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
14041	090	11.47

CPT Descriptor Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30 sq cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 75.0 %

TIME ESTIMATES (Median)	CPT Code: 15100	Key Reference CPT Code: 14041
Median Pre-Service Time	65.00	49 00
Median Intra-Service Time	60.00	135.00
Median Immediate Post-service Time	20.00	27.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	19.0	19.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	76.0	92.00
Median Total Time	**276.00**	**358.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.47	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.37	2.41
Urgency of medical decision making	2.58	2.35

Technical Skill/Physical Effort (Mean)

Technical skill required	2.74	3.18
Physical effort required	2.37	2.47

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2 74	3.06
Outcome depends on the skill and judgment of physician	2.95	3.29
Estimated risk of malpractice suit with poor outcome	2 26	2.76

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.58	2.94
Intra-Service intensity/complexity	2.44	3.25
Post-Service intensity/complexity	2.44	2.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ASPS Consensus Panel recommends the 25th percentile RVW and believes that our survey results justify the current value of code 15100, which was added to the five-year review by CMS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Code 15100 can be reported with the add-on code 15101 to describe areas of grafting beyond the first 100 sq cm. The work RVU for 15101 is 1.72, Global ZZZ, intraservice time 29 minutes (Harvard)

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 9% No 91%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 3% less complex (less work) 0% no change 97%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 15100

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		73.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 73.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 5.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 60.0	Staff % of Physician time **Change:** **In Time** 100% -13.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214: 0.0	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 15240 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **9.4**
RUC RVU: **9.03**

CPT Descriptor: 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old male with an excised basal cell carcinoma on the lower left cheek leaves a defect through the subcutaneous plane that is 2.0 cm diameter. In order to prevent deformity and disfigurement, a full thickness skin graft is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 29%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work begins with assessing the patient taking a history; reviewing current prescriptions, obtaining and reviewing current 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. Additional 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. 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: Beginning after preparation of the defect or wound, a template of the defect is created. The template is transferred to the donor site. The template is oriented to allow harvesting with the least amount of distortion and tension. Additional excision may be incorporated to allow tapering of the edges. The graft in incised with a scapel and then elevated in a subderma plane. The graft is further prepared by removing any remaining subcutaneous tissue from the dermal surface of the graft. The graft is transferred to the recipient site, oriented, contoured as necessary and sutured into position. A tie-over dressing may be applied. Additional undermining of the donor site may be needed to allow tensionless closure. The donor site is closed primarily and a dressing applied '

Description of Post-Service Work: Post-service work begins with monitoring patient stabilization in the operating and recovery room. Operative report is dictated and orders are written. The physician communicates with the family and other health care professionals (including written and oral reports and orders). Same day hospital services, include monitoring the care of the patient, assessment of the graft and donor site dressings, pain control, patient hydration oral intake and critical patient positioning. Discharge management includes; the surgeon's final examination of the patient, discussion of home care and follow up. Completion of discharge forms and prescriptions. Reconciliation of pre-procedure prescriptions. Communication with other health care providers and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005
Presenter(s):	James A. Zalla, MD Keith Brandt, MD, James Denneny III, MD
Specialty(s):	AAD ASPS AAO-HNS
CPT Code:	15240

Sample Size: 357	**Resp n:** 17	**Response:** 4.7 %
Sample Type: Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	9.00	9.05	**9.40**	10.04	11.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	60.00	82.50	**60.00**	120.00	150.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**20.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**122.0**	99211x **0.0** 12x **2.0** 13x **4.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
.5260	090	10.04

CPT Descriptor Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
44950	090	9.99

CPT Descriptor 1 Appendectomy

MPC CPT Code 2	Global	Work RVU
46262	090	7 49

CPT Descriptor 2 Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy; with or without fissurectomy

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 94.1 %

TIME ESTIMATES (Median)	**CPT Code: 15240**	**Key Reference CPT Code: 15260**
Median Pre-Service Time	65.00	47.00
Median Intra-Service Time	60.00	92.00
Median Immediate Post-service Time	20.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	122.0	67.00
Median Total Time	**303.00**	**236.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.33	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 93	3 93
Urgency of medical decision making	4.46	4 40

Technical Skill/Physical Effort (Mean)

Technical skill required	4.73	4.86
Physical effort required	4.40	4.46

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.66	4.73
Outcome depends on the skill and judgment of physician	4.66	4.60
Estimated risk of malpractice suit with poor outcome	4.60	4.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.26	4.40
Intra-Service intensity/complexity	4.66	4.60
Post-Service intensity/complexity	4.53	4.60

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), the merican Society of Plastic Surgeons (ASPS) and the American Association of Otolaryngologists-Head and Neck Surgeons (AAO-HNS) have surveyed this code using one or more panels of members within their respective organizations. The data collected has been reviewed by each society's respective RBRVS committees and is presented here as a joint recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 6% No 94%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 152

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		99.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 99.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.5	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type andratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		60.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 60.0	Staff % of Physician time **Change:** **In Time** 100% -33.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 4.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code: 15734 Global Period: 090 Specialty Society RVU: **18.33**
RUC RVU: **17.76**

CPT Descriptor: Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old female with a history of breast cancer treated with mastectomy followed by radiation therapy presents with a large non-healing radiation ulcer of the left lateral chest. The excision of the radiation ulcer results in exposure of several ribs. The defect is reconstructed with a pedicled latissimus muscle flap. The entire latissimus muscle is harvested through a separate incision and then tunneled through the axilla to reach the defect. The muscle is secured to the chest wall with interrupted sutures and the donor site is closed primarily. The muscle is covered with a split thickness skin graft. The excison and the skin graft are coded separately.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

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 and if necessary 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. Additional 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 latissimus muscle. Dissection is carried down to the fascia, which is elevated off the muscle. The anterior and posterior borders of the muscle are exposed and the dissection continues inferiorly until enough length is obtained to reach the defect. The inferior portion of the muscle is then divided and the muscle elevated off the chest wall and isolated on the thoracodorsal vascular pedicle. A tunnel is created subcutaneously to reach the defect and enlarged to accommodate the muscle flap. The flap is transposed and the vascular pedicle re-assessed. The flap is inset into the chest wall defect and sutured in place after placement of a closed suction drain. The donor site is closed primarily over suction drains. A split-thickness skin graft is harvested from the ipsilateral thigh, meshed and secured to the muscle. A bolster dressing is applied over the skin graft. The skin graft donor site is covered with an occlusive dressing.

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 as well as 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: including removal of sutures: evaluation of periodic imaging, pathology, and laboratory reports, if needed; and antibiotic and pain medication adjustments.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Keith Brandt, MD; Scott Oates, MD					
Specialty(s):	ASPS					
CPT Code:	15734					
Sample Size: 150	**Resp n:** 21	**Response:** 0 00 %				
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	17.00	18.33	**22.00**	24.00	28.00	
Pre-Service Evaluation Time:			**30.0**			
Pre-Service Positioning Time:			**15.0**			
Pre-Service Scrub, Dress, Wait Time:			**15.0**			
Intra-Service Time:	120.00	163.00	**163.00**	210.00	360.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**90.0**	99231x **1.0** 99232x **1.0** 99233x **1.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**114.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **1.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
5738	090	17.89

CPT Descriptor Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 71.4 %

TIME ESTIMATES (Median)	**CPT Code: 15734**	**Key Reference CPT Code: 15738**
Median Pre-Service Time	60.00	69.00
Median Intra-Service Time	163.00	150.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0 00
Median Other Hospital Visit Time	90 0	114 00
Median Discharge Day Management Time	36 0	36 00
Median Office Visit Time	114.0	60 00
Median Total Time	**493.00**	**459.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.47	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.56
Urgency of medical decision making	3.21	3.13

Technical Skill/Physical Effort (Mean)

Technical skill required	4.05	3.75
Physical effort required	4.00	3 31

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.05	3.56
Outcome depends on the skill and judgment of physician	3.89	3.81
Estimated risk of malpractice suit with poor outcome	3.11	2.81

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.74	3.31
Intra-Service intensity/complexity	3.89	3.44
Post-Service intensity/complexity	3.26	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ASPS Consensus Panel recommends the 25th percentile RVW for 15734 instead of the median RVW in order to void rank order problems with other codes in the family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 0% No 100%

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

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 15734

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		194.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 194.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type andratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference ɔetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		163.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 163.0	Staff % of Physician time **Change:** **In Time** 100% 31.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214: 1.0	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 17003 Global Period: ZZZ

Recommended Work Relative Value
Specialty Society RVU: **0.55**
RUC RVU: **0.07**

CPT Descriptor: Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; second through 14 lesions, each (List separately in addition to code for first lesion

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old Caucasian female presents with a scaly, 6x5 mm, erythematous papule, adjacent to the lateral canthus, and three additional lesions, one each on the face, cheek and forehead, each being 5x7 mm of 4 months duration. Inspection and palpation of the lesions is compatible with the diagnosis of a hypertrophic actinic keratosis.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: "Inspect and palpate lesion for size, location, functional risks, depth; Administer local anesthetic; Electro surgical destruction of lesion; Application of dermal curette to lesion, two or more times; Control of bleeding with additional destruction to lesion base using electrocautery unit as needed."

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A. Zalla, MD Bruce Deitchman, MD				
Specialty(s):	Dermatology				
CPT Code:	17003				
Sample Size: 250	**Resp n:** 61	**Response:** 24.4 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	0 18	0 25	**0.55**	0 60	0 77
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	1.00	2.00	**2.00**	5.00	7.00

ost-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**

Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
11201	ZZZ	0.29

CPT Descriptor Removal of skin tags, multiple fibrocutaneous tags, any area; each additional ten lesions (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
17000	010	0.60

CPT Descriptor 1 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion

MPC CPT Code 2	Global	Work RVU
11200	010	0 77

CPT Descriptor 2 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 44.2 %

TIME ESTIMATES (Median)	**CPT Code: 17003**	**Key Reference CPT Code: 11201**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	2.00	5.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**2.00**	**5.00**
ther time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3 00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.00
Urgency of medical decision making	3.00	2.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3 00	3 00
Physical effort required	2.00	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.00
Outcome depends on the skill and judgment of physician	3.00	3.00
Estimated risk of malpractice suit with poor outcome	3.00	2.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.00
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	2.00	2.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has irveyed this code using one or more panels of members within this organization. The data collected has been reviewed oy the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 13% No 87%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 17003

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		2.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 2.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff typeand ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		2.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 2.0	Staff % of Physician time **Change: In Time** 100% 0 0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:17262 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.7**
RUC RVU: **1.58**

CPT Descriptor: Destruction, malignant lesion (e.g., e.g. laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72 year old man has a biopsy proven 1.4 cm superficial spreading basal cell carcinoma of the lower back.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-operative evaluation, including review of pertinent data in medical records. Discussion of choice of treatment or service options. Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias. Informed consent. Necessary instructions to patient and staff. Procedural preparation - electrosurgical equipment, disposable supplies and chemical hemostatic agents. Preparation of non-disposable equipment - including multiple curettes, forceps and scissors. Communications with family members accompanying patient if present

Description of Intra-Service Work: Inspect and palpate lesion for size, location, functional risks, and depth. Marking of clinical margins using magnification. Administer local anesthetic. Application of dermal curettes of decreasing size to lesion and adjacent margins, three or more times alternating with electrosurgical destructions as needed Control of bleeding with additional chemical hemostatic or electrocautery as needed

Description of Post-Service Work: Apply antibiotic ointment. Apply dressing, when appropriate. Instruct patient on wound care, functional risks, risk of recurrence and need for long term follow up. Instruct staff to schedule post-operative visit. . Communication with patient and family on post-operative care and follow-up. Completion of medical record charting, including dictation of operative report and communication to referring physician, if appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	James A. Zalla MD Bruce Deitchman, MD				
Specialty(s):	AAD				
CPT Code:	17262				
Sample Size:	250	**Resp n:** 44	**Response:** 17.6 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	1.00	1.58	**1.70**	2.00	3.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**3.0**		

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		8.00	10.00	**15.00**	20.00	25.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**15.0**	99211x **0.0**	12x **1.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
1313	000	1.62

CPT Descriptor Shaving of dermal or dermal lesion, single lesions, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 2.0 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11750	010	1.86

CPT Descriptor 1 Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal;

MPC CPT Code 2	Global	Work RVU
17000	010	0.60

CPT Descriptor 2 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 22.7 %

TIME ESTIMATES (Median)	CPT Code: 17262	Key Reference CPT Code: 11313
Median Pre-Service Time	8.00	10.00
Median Intra-Service Time	15.00	12.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15 0	15 00
Median Total Time	**43.00**	**42.00**

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.36	2.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	2.41
Urgency of medical decision making	3.21	2.46

Technical Skill/Physical Effort (Mean)

Technical skill required	3.38	2.97
Physical effort required	3.21	2.78

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.36	2 87
Outcome depends on the skill and judgment of physician	3.47	3.13
Estimated risk of malpractice suit with poor outcome	3.31	2.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	2.69
Intra-Service intensity/complexity	3.30	2 85
Post-Service intensity/complexity	3.00	2.68

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 18% No 82%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work)
   I agree 12% I do not agree 87%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 17262

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		18.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 11.0	Staff % of Physician time 61%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		15.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 9.0	Staff % of Physician time **Change:** **In Time** 61% -2.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:17281 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **1.8**
RUC RVU: **1.72**

CPT Descriptor: Destruction, malignant lesion (e.g., e.g. laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 85 year old male has a 1.0 cm basal cell carcinoma on the left forehead. Because of back problems, he cannot have excision and repair of the lesion nor is he concerned about cosmetic outcome.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-operative evaluation, including review of pertinent data in medical records. Discussion of choice of treatment or service options. Review medical risks, such as syncope, bleeding, pain, edema, infection, headache, delayed healing, scarring, pigmentation, recurrence, paresthesias. Informed consent. Necessary instructions to patient and staff. Procedural preparation - electrosurgical equipment, disposable supplies and chemical hemostatic agents. Preparation of non-disposable equipment - including multiple curettes, forceps and scissors. Communications with family members accompanying patient if present

Description of Intra-Service Work: Inspect and palpate lesion for size, location, functional risks, and depth. Marking of clinical margins using magnification. Administer local anesthetic. Application of dermal curettes of decreasing size to lesion and adjacent margins, three or more times alternating with electrosurgical destructions as needed. Control of bleeding with additional chemical hemostatic or electrocautery as needed

Description of Post-Service Work: Apply antibiotic ointment. Apply dressing, when appropriate. Instruct patient on wound care, functional risks, risk of recurrence and need for long term follow up. Instruct staff to schedule post-operative visit/. Communication with patient and family on post-operative care and follow-up. Completion of medical record charting, including dictation of operative report and communication to referring physician, if appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James A. Zalla, MD Bruce Deitchman, MD					
Specialty(s):	AAD					
CPT Code:	17281					
Sample Size:	250	**Resp n:** 49		**Response:** 19.6 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1 10	1 75	**1.80**	2 00	2 78
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**3.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		

Intra-Service Time:		7.50	10.00	**14.00**	18.00	20.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**15.0**	99211x **0.0**	12x **1.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
1313	000	1.62

CPT Descriptor Shaving of dermal or dermal lesion, single lesions, face, ears, eyelids, nose, lips, mucous membrane, lesion diameter over 2.0 cm

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
11750	010	1 86

CPT Descriptor 1 Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal;

MPC CPT Code 2	Global	Work RVU
17000	010	0.60

CPT Descriptor 2 Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 26.5 %

TIME ESTIMATES (Median)	**CPT Code: 17281**	**Key Reference CPT Code: 11313**
Median Pre-Service Time	8.00	10.00
Median Intra-Service Time	14.00	12.00
Median Immediate Post-service Time	5.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	15.0	15.00
Median Total Time	**42.00**	**42.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.40	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	2.77
Urgency of medical decision making	3.26	2.77

Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	3.16
Physical effort required	3.13	2.98

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.42	2.98
Outcome depends on the skill and judgment of physician	3.58	3.17
Estimated risk of malpractice suit with poor outcome	3.31	2.85

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.21	2.85
Intra-Service intensity/complexity	3.26	3.04
Post-Service intensity/complexity	3.04	2.85

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

As required by the Centers for Medicare and Medicaid Services, the American Academy of Dermatology (AAD), has surveyed this code using one or more panels of members within this organization. The data collected has been reviewed by the society's Health Care Finance Committee (RBRVS) committee and is presented here as its recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 24% No 76%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 8% I do not agree 82%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 17281

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		18.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 12.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		14.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 10.0	Staff % of Physician time **Change:** **In Time** 67% -2.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21145 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **23.5**
RUC RVU: **21.84**

CPT Descriptor: Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-year-old male is seen for surgical correction of a developmental deformity of the facial skeleton. It is manifested by maxillary hypoplasia and retrusion, and a Class III malocclusion. Cephalometric analysis confirms horizontal maxillary deficiency. Preoperative cephalometric analysis and prediction tracings are done Dental casts are mounted on an articulator, model surgery is carried out, and an acrylic splint(s) for use intraoperatively is fabricated.

Intraoperatively, ostectomies are performed. The maxilla is advanced and seated appropriately, utilizing the prefabricated splint(s). Cancellous bone is harvested from the anterior iliac crest and grafted into the maxilla. Rigid internal fixation is applied.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: ☐ Review pre-operative workup, including: History and Physical examination, consultations from Neurosurgery, Ophthalmology; review laboratory results (CBC, Electrolytes, nutritional parameters); review of CT scans and discussion with radiologist; review of ventilatory status and chest x-ray

☐ Review planned procedure, incisions. Communicate with operating room regarding needed equipment
☐ Review articulated dental models, panorex, cephalograms.
☐ Review fit of acrylic dental splint on articulated dental models.
☐ Review planned movement of maxilla in all three dimensions with orthodontist.
☐ Discuss plans with patient, if possible, and patient's family, including incisions, risks, and potential complications
☐ Obtain informed consent.
☐ Write pre-operative orders for peri-operative medications, arrange for post-op intensive care unit monitoring if needed.

Pre-service work-- Day of surgery

☐ Confirm that patient is cleared for OR with trauma service.
☐ Change into scrub clothes
☐ Check with lab on blood availability
☐ Discuss length and type of anesthesia with anesthesiologist
☐ Discuss case plan, equipment and supplies needs, positioning with OR nurses and surgical assistants
☐ Review procedure and expected recovery with patient and family
☐ Check fit of acrylic dental splint on patient's dentition
☐ Answer any patient and family questions
☐ Verify antibiotic administration, and prophylaxis for deep venous thrombosis.
☐ Monitor patient positioning, assist as needed in moving patient
☐ Insert Foley Catheter
☐ Place padding on all pressure points, assure head support is appropriate

- ☐ (If tracheostomy being done first by another service, wait on-call until this is done (generally 30-60 minutes)
- ☐ Place corneal protectors in eyes to provide protection during surgical procedure
- ☐ Prep patient, including scalp, face, intraoral areas
- ☐ Scrub and gown.

Description of Intra-Service Work: ☐ Arch bars are placed on the upper and lower teeth

☐ The distance from the medial canthus to the inferior edge of the central incisor is measured with a caliper and recorded.

☐ The upper labial and buccal sulci are injected with epinephrine, and a waiting period is done The first side buccal sulcus incision is made, taking care to reserve a "cuff" of tissue attached to the gingiva. A subperiosteal dissection is performed to the level of the piriform aperture, the orbital rim, and the posterior zygomatic buttress is done Care is taken to preserve the intraorbital nerve. The procedure is repeated on the second side.

☐ Extensive dissection of the soft tissue is performed on the posterior maxilla at the level of the pterygo-maxillary fissure in order to free this area, and submucosal dissection is performed on the lateral nasal side wall (medial maxiallary sinus wall .

☐ An osteotomy is marked on both of the anterior maxillary walls and checked for symmetry. These anterior maxillary osteotomies are then performed with a reciprocating saw.

☐ An osteotomy is then made through each of the lateral nasal side walls (medial maxillary sinus wall) using the osteotome.

☐ On each side of the face, the curved osteotome is then introduced behind the maxillary tuberosity and guided into the pterygo-maxillary fissure. Disjunction of the maxilla is then accomplished by several taps with a mallet on each side

☐ The maxilla is the "down-fractured" using digital pressure.

☐ If the bone fragments do not move sufficiently to get the teeth into occlusion, bone reduction forceps are introduced into the nose and mouth, and the maxilla is disimpacted and mobilized until it can be completely mobilized. Great care is taken to maintain the integrity of the blood supply to the maxilla and the palate.

☐ The maxillary dentition is fitted to the acrylic splint and the acrylic splint is then wired into place to the arch bars. The patient is then wired into maxillomandibular fixation.

☐ The distance from the medial canthus to the inferior edge of the central incisor is measured with a caliper and the degree of vertical maxillary impaction or expansion is recorded.

☐ Metallic templates are configure to the osteotomy site medially along the piriform aperture. These templates are then used to shape the metallic fixation plates with appropriate vertical and horizontal movement of the maxilla. These medial plates are secured in place with a drill and screw. All relationships of the maxilla are then measured and confirmed, including the vertical change from the medial canthus.

☐ Metallic templates are configure to the osteotomy site laterally along the zygomatic buttress. These templates are then used to shape the metallic fixation plates with appropriate vertical and horizontal movement of the maxilla. These lateral zygomatic buttress plates are then secured in place with a drill and screws. All relationships of the maxilla are then measured and confirmed, including the vertical change from the medial canthus.

☐ Using a separate set of instruments to avoid oral contamination of the bone graft donor site and attendant risk of infection, a separate incision is then marked above the iliac crest. This in infiltrated with local anesthetic with epinephrine. After five to seven minutes, a skin incision is made and carried down onto muscle fascia. Flaps are elevated to enhance exposure. The soft tissue is dissected off of the medial iliac cortical plate.

☐ Two vertical osteotomies are made through the iliac crest and a segment of the cap of the iliac crest is removed. The iliac cancellous bone is harvested using a curette and placed in saline. After adequate cancellous bone is harvested, additional cortical bone may be harvested from the cortical plate, depending on specific clinical needs. Hemostasis is obtained and the iliac crest cap is then secured in place by placing drill holes through the intact iliac crest and the fragment and securing with suture material. The periosteum is closed over this area, followed by muscle closure and skin closure.

☐ The bone graft is then placed in the maxilla on both sides and packed in place.

☐ At the conclusion of the fixation, the intermaxillary fixation is again assessed, and released. The excursion of the mandible is assessed and the position of the maxilla in relation to the mandible is assessed without intermaxillary fixation. If the occlusion is not accurate, the patient must be placed in intermaxillary fixation again, the plates and screws must be

removed, and the plate fixation of the midface repeated until a satisfactory relationship is obtained. Depending upon clinical considerations, the patient may remain in intermaxillary fixation, or it may be released.

☐ The incisions are irrigated. Intraoral wound closure is done with single layer absorbable suture. This is done for both incisions. The corneal shields are removed.

Description of Post-Service Work: ☐ The hair is washed to remove all blood.

☐ The tracheostomy, if present, is checked to make sure it is secure. Extubation and post-extubation monitoring is performed, if possible. All tubing is secured, and patient is moved to bed. Patient is moved to recovery room.

☐ Dictate op note

☐ Sign all OR forms, including written op note of pre and post op diagnosis, operations performed, assistants, findings. Communicate with anesthesia personnel for blood loss and fluid administration for notes. Inform OR staff of CPT coding for their records.

☐ Write post op orders for x-rays, medications, IV fluids, ventilator settings, diet, and activities.

☐ Review findings and procedures with orthodontist and family doctor. Coordinate care.

☐ Discuss findings and procedures with family.

Post op same day work after discharge from recovery:

☐ Examine patient, check wounds, vital signs, and lab work

☐ Review nursing, other staff chart notes

☐ Review findings and treatment with patient when awake.

☐ Answer nursing/ other staff questions

☐ Answer family/patient questions

☐ Review critical care elements including ventilator, heart rate and rhythm, neurology, status of vision and lab tests ncluding CBC, blood gasses

☐ Order next day labs and x-rays, and any other order changes

☐ Chart progress notes

Post-op other hospital work (post op day 1 to discharge)

☐ Examine and talk with patient. Check wounds, vision, neuro status

☐ Extubate or wean from ventilator as required.

☐ Review post reduction films.

☐ Review nursing and other staff notes.

☐ Review vital signs, I&O, lab work

☐ Answer nursing/other staff questions

☐ Answer patient/family questions

Answer insurance staff questions

☐ Discuss post-discharge disposition with social worker

☐ Write orders for labs, meds, diet, and activity

☐ Chart progress notes

☐ Transfer from ICU as appropriate

Discharge day work:

Examine and talk with patient. Answer questions patient/family

☐ Check final labs/films/tests, discuss results with patient.

☐ Answer nursing/other staff questions

☐ Answer insurance questions

- ☐ Write orders for post-discharge tests
  Write prescriptions for medications
- ☐ Chart discharge note
- ☐ Dictate discharge summary

Post op office work:

- ☐ Examine and talk with patient
- ☐ Check wounds, remove sutures, check IMF and adjust wires if needed.
- ☐ Answer patient/family questions
- ☐ Monitor rehab, review records from rehab facility.
- ☐ Discuss patient with referring and consulting physicians. (verbal and written)
- ☐ Coordinate care with other physicians.
- ☐ Discuss patient with insurance nurses or medical directors.
  Write prescriptions for medications
- ☐ Review post discharge labs and films
- ☐ Fill out paperwork for insurance, disability, work excuses, visiting nurse, etc.
- ☐ Discuss progress and plans with patient/family.
- ☐ Write patient progress note.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005
Presenter(s):	Keith Brandt, MD; Robert Havlik, MD; Timothy S. Shahbazian, DDS
Specialty(s):	ASPS, AAOMS
CPT Code:	21145

Sample Size: 0	**Resp n:** 0	**Response:** 0.00 %

Sample Type:

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.00	0.00	**0.00**	0.00	0.00
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	0.00	0.00	**0.00**	0.00	0.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**30.0**	99231x **0.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**45.0**	99238x **0.00** 99239x **1.00**
Office time/visit(s):	**121.0**	99211x **0.0** 12x **3.0** 13x **0.0** 14x **2.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
21141	090	19.91

CPT Descriptor Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
20902	090	7.54

CPT Descriptor Bone graft, any donor area; major or large

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 37.9 %

TIME ESTIMATES (Median)	CPT Code: 21145	Key Reference CPT Code: 21141
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	0.00	0.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	0.00
Median Discharge Day Management Time	45.0	0.00
Median Office Visit Time	121.0	0.00
Median Total Time	**196.00**	**0.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	4.00
Urgency of medical decision making	2.54	2.62

Technical Skill/Physical Effort (Mean)

Technical skill required	4.30	4.21
Physical effort required	3.93	3.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.96
Outcome depends on the skill and judgment of physician	4.44	4.32
Estimated risk of malpractice suit with poor outcome	4.30	4.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.93	3.86
Intra-Service intensity/complexity	4.07	3.96
Post-Service intensity/complexity	3.37	3.29

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ASPS and AAOMS Consensus Panel considers the work of 21145 to be equivalent to CPT 21141 (work RVW 8.07) plus CPT 20902 (work RVW 7.54), which is 25.61 RVW. However, we are limited by our survey results. Therefore, we are recommending the 75th percentile RVW of 23.50.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 28% No 72%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 38% I do not agree 62%
B. Patients requiring this service are now:
   more complex (more work) 62% less complex (less work) 0% no change 38%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 13% no change 87%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 21145

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213:	
		99214: 0.0	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21146 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **27.50**
RUC RVU: **22.85**

CPT Descriptor: Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old male who was born with a unilateral complete cleft lip and palate presents for treatment of remaining cleft-related deformities. He has previously undergone repair of the cleft lip and the cleft palate. The alveolar cleft was never corrected. He has developed midface retrusion and a Class III malocclusion with a unilateral posterior cross-bite. Preoperative cephalometric analysis and prediction tracings are done Dental casts are mounted on an articulator, model surgery is carried out, and an acrylic splint(s) for use intraoperatively is fabricated.

Intraoperatively, a segmental two piece LeFort I osteotomy is performed. The maxilla is advanced and seated appropriately, utilizing the prefabricated splint(s). Cancellous bone is harvested from the anterior iliac crest and grafted into the maxilla. Rigid internal fixation is applied.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: ☐ Review pre-operative workup, including: History and Physical examination, consultations from Neurosurgery, Ophthalmology; review laboratory results (CBC, Electrolytes, nutritional parameters); review of CT scans and discussion with radiologist; review of ventilatory status and chest x-ray

☐ Review planned procedure, incisions. Communicate with operating room regarding needed equipment
☐ Review articulated dental models, panorex, and cephalograms.
☐ Review fit of acrylic dental splint on articulated dental models.
☐ Review planned movement of maxilla in all three dimensions with orthodontist.
☐ Discuss plans with patient, if possible, and patient's family, including incisions, risks, and potential complications
☐ Obtain informed consent.
☐ Write pre-operative orders for peri-operative medications, arrange for post-op intensive care unit monitoring if needed.

Pre-service work-- Day of surgery

☐ Confirm that patient is cleared for OR with trauma service.
☐ Change into scrub clothes
☐ Check with lab on blood availability
☐ Discuss length and type of anesthesia with anesthesiologist
☐ Discuss case plan, equipment and supplies needs, positioning with OR nurses and surgical assistants
☐ Review procedure and expected recovery with patient and family

☐ Answer any patient and family questions
☐ Verify antibiotic administration, and prophylaxis for deep venous thrombosis.
☐ Monitor patient positioning, assist as needed in moving patient
☐ Insert Foley Catheter
☐ Place padding on all pressure points, assure head support is appropriate

□ (If tracheostomy being done first by another service, wait on-call until this is done (generally 30-60 minutes)
□ Place corneal protectors in eyes to provide protection during surgical procedure
□ Prep patient, including scalp, face, intraoral areas
□ Scrub and gown.

Description of Intra-Service Work: □ Arch bars are placed on the upper and lower teeth

□ The distance from the medial canthus to the inferior edge of the central incisor is measured with a caliper and recorded.
□ The upper labial and buccal sulci are injected with epinephrine, and a waiting period is done. The first side buccal sulcus incision is made, taking care to reserve a "cuff" of tissue attached to the gingiva. A subperiosteal dissection is performed to the level of the piriform aperture, the orbital rim, and the posterior zygomatic buttress is done. Care is taken to preserve the intraorbital nerve. The procedure is repeated on the second side.
□ Extensive dissection of the soft tissue is performed on the posterior maxilla at the level of the pterygo-maxillary fissure in order to free this area, and submucosal dissection is performed on the lateral nasal side wall (medial maxillary sinus wall.
□ An osteotomy is marked on both of the anterior maxillary walls and checked for symmetry. These anterior maxillary osteotomies are then performed with a reciprocating saw.
□ An osteotomy is then made through each of the lateral nasal side walls (medial maxillary sinus wall) using the osteotome.
□ On each side of the face, the curved osteotome is then introduced behind the maxillary tuberosity and guided into the pterygo-maxillary fissure. Disjunction of the maxilla is then accomplished by several taps with a mallet on each side.
□ The maxilla is the "down-fractured" using digital pressure.

□ If the bone fragments do not move sufficiently to get the teeth into occlusion, bone reduction forceps are introduced into the nose and mouth, and the maxilla is disimpacted and mobilized until it can be completely mobilized. Great care is taken to maintain the integrity of the blood supply to the maxilla and the palate.
□ An osteotomy is then performed through the maxilla. Care is taken to insure the integrity of the oral mucosa below he osteotomy site. The maxilla is separated into two pieces.
□ The maxillary dentition is fitted to the acrylic splint and the acrylic splint is then wired into place to the arch bars. The patient is then wired into maxillomandibular fixation.
□ The distance from the medial canthus to the inferior edge of the central incisor is measured with a caliper and the degree of vertical maxillary impaction or expansion is recorded.
□ Metallic templates are configured to the osteotomy site medially along the piriform aperture. These templates are then used to shape the metallic fixation plates with appropriate vertical and horizontal movement of the maxilla. These medial plates are secured in place with a drill and screw. All relationships of the maxilla are then measured and confirmed, including the vertical change from the medial canthus.
□ Metallic templates are configure to the osteotomy site laterally along the zygomatic buttress. These templates are then used to shape the metallic fixation plates with appropriate vertical and horizontal movement of the maxilla. These lateral zygomatic buttress plates are then secured in place with a drill and screws. All relationships of the maxilla are then measured and confirmed, including the vertical change from the medial canthus.
□ Using a separate set of instruments to avoid oral contamination of the bone graft donor site and attendant risk of infection, a separate incision is then marked above the iliac crest. This in infiltrated with local anesthetic with epinephrine. After five to seven minutes, a skin incision is made and carried down onto muscle fascia. Flaps are elevated to enhance exposure. The soft tissue is dissected off of the medial iliac cortical plate.
□ Two vertical osteotomies are made through the iliac crest and a segment of the cap of the iliac crest is removed. The iliac cancellous bone is harvested using a curette and placed in saline. After adequate cancellous bone is harvested, additional cortical bone may be harvested from the cortical plate, depending on specific clinical needs. Hemostasis is obtained and the iliac crest cap is then secured in place by placing drill holes through the intact iliac crest and the fragment and securing with suture material. The periosteum is closed over this area, followed by muscle closure and skin closure.

The bone graft is then placed in the maxilla on both sides and packed in place. The gap between the maxillary segments is packed with bone graft.
□ At the conclusion of the fixation, the intermaxillary fixation is again assessed, and released. The excursion of the mandible is assessed and the position of the maxilla in relation to the mandible is assessed without intermaxillary fixation.

If the occlusion is not accurate, the patient must be placed in intermaxillary fixation again, the plates and screws must be removed, and the plate fixation of the midface repeated until a satisfactory relationship is obtained Depending upon clinical considerations, the patient may remain in intermaxillary fixation, or it may be released.

☐ The incisions are irrigated. Intraoral wound closure is done with single layer absorbable suture. This is done for both incisions. The corneal shields are removed.

Description of Post-Service Work: ☐ The hair is washed to remove all blood.
☐ The tracheostomy, if present, is checked to make sure it is secure. Patient extubation and post-extubation monitoring are performed if possible. All tubing is secured, and patient is moved to bed. Patient is moved to recovery room.
☐ Dictate op note
☐ Sign all OR forms, including written op note of pre and post op diagnosis, operations performed, assistants, findings. Communicate with anesthesia personnel for blood loss and fluid administration for notes. Inform OR staff of CPT coding for their records.
☐ Write post op orders for x-rays, medications, IV fluids, ventilator settings, diet, and activities.
☐ Review findings and procedures with orthodontist and family doctor. Coordinate care.
☐ Discuss findings and procedures with family.

Post op same day work after discharge from recovery:

☐ Examine patient, check wounds, vital signs, and lab work
☐ Review nursing, other staff chart notes

☐ Review findings and treatment with patient when awake.
☐ Answer nursing/ other staff questions
☐ Answer family/patient questions
☐ Review critical care elements including ventilator, heart rate and rhythm, neurology, status of vision and lab tests including CBC, blood gasses
☐ Order next day labs and x-rays, and any other order changes
☐ Chart progress notes

Post-op other hospital work (post op day 1 to discharge)

☐ Examine and talk with patient. Check wounds, vision, neuro status
☐ Extubate or wean from ventilator as required.
☐ Review post reduction films.

☐ Review nursing and other staff notes.
☐ Review vital signs, I&O, lab work
☐ Answer nursing/other staff questions
☐ Answer patient/family questions
Answer insurance staff questions
☐ Discuss post-discharge disposition with social worker

☐ Write orders for labs, meds, diet, and activity
☐ Chart progress notes
☐ Transfer from ICU as appropriate

Discharge day work:

Examine and talk with patient. Answer questions patient/family
☐ Check final labs/films/tests, discuss results with patient.

☐ Answer nursing/other staff questions
☐ Answer insurance questions

- ☐ Write orders for post-discharge tests
  Write prescriptions for medications
- ☐ Chart discharge note
- ☐ Dictate discharge summary

Post op office work:

- ☐ Examine and talk with patient
- ☐ Check wounds, remove sutures, check IMF and adjust wires if needed.
- ☐ Answer patient/family questions
- ☐ Monitor rehab, review records from rehab facility.
- ☐ Discuss patient with referring and consulting physicians. (verbal and written)
- ☐ Coordinate care with other physicians.
- ☐ Discuss patient with insurance nurses or medical directors.
  Write prescriptions for medications
- ☐ Review post discharge labs and films
- ☐ Fill out paperwork for insurance, disability, work excuses, visiting nurse, etc.
- ☐ Discuss progress and plans with patient/family.
- ☐ Write patient progress note.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Keith Brandt, MD; Robert Havlik, MD; Timothy S. Shahbazian, DDS					
Specialty(s):	ASPS, AAOMS					
CPT Code:	21146					
Sample Size: 0	**Resp n:** 0		**Response:** 0 00 %			
Sample Type:						
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.00	0.00	**0.00**	0 00	0 00	
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	0.00	0.00	**0.00**	0.00	0.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
21151	090	28.26

CPT Descriptor Reconstruction midface, LeFort I; two pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
21142	090	18 78

CPT Descriptor Reconstruction midface, LeFort 1; two pieces, segment movement in any direction without bone graft

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	CPT Code: 21146	Key Reference CPT Code: 21151
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	0.00	305.00
Median Immediate Post-service Time	0.00	76.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0 0	90.00
Median Total Time	**0.00**	**471.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.11	4.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4 16
Urgency of medical decision making	2.77	2.78

Technical Skill/Physical Effort (Mean)

Technical skill required	4.70	4 56
Physical effort required	4 22	4 08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.37	4.28
Outcome depends on the skill and judgment of physician	4.59	4.52
Estimated risk of malpractice suit with poor outcome	4.48	4.32

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.26	4.20
Intra-Service intensity/complexity	4.48	4.28
Post-Service intensity/complexity	3.59	3.44

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ASPS and AAOMS Consensus Panel recommends the median RVW of 27.5 supported by our survey results. As further support, the Consensus Panel points out the work of 21146 is approximately equivalent to CPT 21142 (work RVW 18.78) plus CPT 20902 (work RVW 7.54), which is 26.32 RVW.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 28% No 72%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 38% I do not agree 62%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) 0% no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 21146

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staffintra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.0	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213: 0.0	
		99214: 0.0	
		99215: 0.0	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:21147 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **28.13**
RUC RVU: **23.32**

CPT Descriptor: Reconstruction midface, LeFort I; three or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-year-old male is seen for surgical correction of a developmental deformity of the facial skeleton. It is manifested by an anterior open bite, maxillary hypoplasia and retrusion, and a Class III malocclusion. Preoperative cephalometric analysis and prediction tracings are done. Dental casts are mounted on an articulator, model surgery is carried out, and an acrylic splint(s) for use intraoperatively is fabricated.

Intraoperatively, a segmental three piece LeFort I osteotomy is performed. The maxilla is advanced so the maxillary and mandibular teeth are seated into the splint, and maxillomandibular fixation is performed. Large gaps remain between the maxillary segments and the proximal portion of the maxilla. Cancellous bone is harvested from the anterior iliac crest and grafted into the maxilla. Rigid internal fixation is applied

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: ☐ Review pre-operative workup, including: History and Physical examination. consultations from Neurosurgery, Ophthalmology; review laboratory results (CBC, Electrolytes, nutritional parameters), review of CT scans and discussion with radiologist; review of ventilatory status and chest x-ray

☐ Review planned procedure, incisions. Communicate with operating room regarding needed equipment
☐ Review articulated dental models, panorex, cephalograms.
☐ Review fit of acrylic dental splint on articulated dental models.
☐ Review planned movement of maxilla in all three dimensions with orthodontist.
☐ Discuss plans with patient, if possible, and patient's family, including incisions, risks, and potential complications
☐ Obtain informed consent.
☐ Write pre-operative orders for peri-operative medications, arrange for post-op intensive care unit monitoring if needed.

Pre-service work-- Day of surgery

☐ Confirm that patient is cleared for OR with trauma service.
☐ Change into scrub clothes
☐ Check with lab on blood availability
☐ Discuss length and type of anesthesia with anesthesiologist
☐ Discuss case plan, equipment and supplies needs, positioning with OR nurses and surgical assistants
☐ Review procedure and expected recovery with patient and family
☐ Answer any patient and family questions
☐ Verify antibiotic administration, and prophylaxis for deep venous thrombosis.
☐ Monitor patient positioning, assist as needed in moving patient
☐ Insert Foley Catheter
☐ Place padding on all pressure points, assure head support is appropriate

☐ (If tracheostomy being done first by another service, wait on-call until this is done (generally 30-60 minutes)

□ Place corneal protectors in eyes to provide protection during surgical procedure
□ Prep patient, including scalp, face, intraoral areas
Scrub and gown.

Description of Intra-Service Work: □ Arch bars are placed on the upper and lower teeth

□ The distance from the medial canthus to the inferior edge of the central incisor is measured with a caliper and recorded.
□ The upper labial and buccal sulci are injected with epinephrine, and a waiting period is done. The first side buccal sulcus incision is made, taking care to reserve a "cuff" of tissue attached to the gingiva. A subperiosteal dissection is performed to the level of the piriform aperture, the orbital rim, and the posterior zygomatic buttress is done. Care is taken to preserve the intraorbital nerve. The procedure is repeated on the second side.
□ Extensive dissection of the soft tissue is performed on the posterior maxilla at the level of the pterygo-maxillary fissure in order to free this area, and submucosal dissection is performed on the lateral nasal side wall (medial maxiallary sinus wall.
□ An osteotomy is marked on both of the anterior maxillary walls and checked for symmetry These anterior maxillary osteotomies are then performed with a reciprocating saw.
□ An osteotomy is then made through each of the lateral nasal side walls (medial maxillary sinus wall) using the osteotome.
□ On each side of the face, the curved osteotome is then introduced behind the maxillary tuberosity and guided into the pterygo-maxillary fissure. Disjunction of the maxilla is then accomplished by several taps with a mallet on each side
□ The maxilla is the "down-fractured" using digital pressure.

□ If the bone fragments do not move sufficiently to get the teeth into occlusion, bone reduction forceps are introduced into the nose and mouth, and the maxilla is disimpacted and mobilized until it can be completely mobilized. Great care is taken to maintain the integrity of the blood supply to the maxilla and the palate.
□ Two osteotomies are then performed through the maxilla. Care is taken to insure the integrity of the oral mucosa elow the osteotomy site. The maxilla is separated into three pieces.
□ The maxillary dentition is fitted to the acrylic splint and the acrylic splint is then wired into place to the arch bars. The patient is then wired into maxillomandibular fixation.
□ The distance from the medial canthus to the inferior edge of the central incisor is measured with a caliper and the degree of vertical maxillary impaction or expansion is recorded.
□ Metallic templates are configure to the osteotomy site medially along the piriform aperture. These templates are then used to shape the metallic fixation plates with appropriate vertical and horizontal movement of the maxilla. These medial plates are secured in place with a drill and screw. All relationships of the maxilla are then measured and confirmed, including the vertical change from the medial canthus.
□ Metallic templates are configure to the osteotomy site laterally along the zygomatic buttress. These templates are then used to shape the metallic fixation plates with appropriate vertical and horizontal movement of the maxilla. These lateral zygomatic buttress plates are then secured in place with a drill and screws. All relationships of the maxilla are then measured and confirmed, including the vertical change from the medial canthus.
□ Using a separate set of instruments to avoid oral contamination of the bone graft donor site and attendant risk of infection, a separate incision is then marked above the iliac crest. This in infiltrated with local anesthetic with epinephrine. After five to seven minutes, a skin incision is made and carried down onto muscle fascia. Flaps are elevated to enhance exposure. The soft tissue is dissected off of the medial iliac cortical plate.
□ Two vertical osteotomies are made through the iliac crest and a segment of the cap of the iliac crest is removed. The iliac cancellous bone is harvested using a curette and placed in saline. After adequate cancellous bone is harvested, additional cortical bone may be harvested from the cortical plate, depending on specific clinical needs. Hemostasis is obtained and the iliac crest cap is then secured in place by placing drill holes through the intact iliac crest and the fragment and securing with suture material. The periosteum is closed over this area, followed by muscle closure and skin closure.
The bone graft is then placed in the maxilla on both sides and packed in place. The gap between the three maxillary segments is packed with bone graft.

☐ At the conclusion of the fixation, the intermaxillary fixation is again assessed, and released The excursion of the mandible is assessed and the position of the maxilla in relation to the mandible is assessed without intermaxillary fixation If the occlusion is not accurate, the patient must be placed in intermaxillary fixation again, the plates and screws must be removed, and the plate fixation of the midface repeated until a satisfactory relationship is obtained. Depending upon clinical considerations, the patient may remain in intermaxillary fixation, or it may be released.

☐ The incisions are irrigated. Intraoral wound closure is done with single layer absorbable suture. This is done for both incisions. The corneal shields are removed.

Description of Post-Service Work:

☐ The hair is washed to remove all blood.

☐ The tracheostomy, if present, is checked to make sure it is secure. Patient extubation and post-extubation monitoring are performed if possible. All tubing is secured, and patient is moved to bed. Patient is moved to recovery room.

☐ Dictate op note

☐ Sign all OR forms, including written op note of pre and post op diagnosis, operations performed, assistants, findings. Communicate with anesthesia personnel for blood loss and fluid administration for notes. Inform OR staff of CPT coding for their records.

☐ Write post op orders for x-rays, medications, IV fluids, ventilator settings, diet, and activities.

☐ Review findings and procedures with orthodontist and family doctor. Coordinate care.

☐ Discuss findings and procedures with family.

Post op same day work after discharge from recovery:

☐ Examine patient, check wounds, vital signs, and lab work

☐ Review nursing, other staff chart notes

☐ Review findings and treatment with patient when awake.

☐ Answer nursing/ other staff questions

☐ Answer family/patient questions

☐ Review critical care elements including ventilator, heart rate and rhythm, neurology, status of vision and lab tests including CBC, blood gasses

☐ Order next day labs and x-rays, and any other order changes

☐ Chart progress notes

Post-op other hospital work (post op day 1 to discharge)

☐ Examine and talk with patient. Check wounds, vision, neuro status

☐ Extubate or wean from ventilator as required.

☐ Review post reduction films.

☐ Review nursing and other staff notes.

☐ Review vital signs, I&O, lab work

☐ Answer nursing/other staff questions

☐ Answer patient/family questions

Answer insurance staff questions

☐ Discuss post-discharge disposition with social worker

☐ Write orders for labs, meds, diet, and activity

☐ Chart progress notes

☐ Transfer from ICU as appropriate

Discharge day work:

☐ Examine and talk with patient. Answer questions patient/family

☐ Check final labs/films/tests, discuss results with patient.

Answer nursing/other staff questions
Answer insurance questions
Write orders for post-discharge tests
Write prescriptions for medications
Chart discharge note
Dictate discharge summary

Post op office work:

Examine and talk with patient
Check wounds, remove sutures, check IMF and adjust wires if needed.
Answer patient/family questions
Monitor rehab, review records from rehab facility.
Discuss patient with referring and consulting physicians. (verbal and written)
Coordinate care with other physicians.
Discuss patient with insurance nurses or medical directors.
Write prescriptions for medications
Review post discharge labs and films
Fill out paperwork for insurance, disability, work excuses, visiting nurse, etc.

☐ Discuss progress and plans with patient/family.
☐ Write patient progress note.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Keith Brandt, MD; Robert Havlik, MD; Timothy S. Shshbazian, DDS					
Specialty(s):	ASPS, AAOMS					
CPT Code:	21147					
Sample Size:	0	**Resp n:** 0		**Response:** 0.00 %		
Sample Type:						
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0 00	0 00	**0.00**	0 00	0 00
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		0.00	0.00	**0.00**	0.00	0.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
21151	090	28.26

CPT Descriptor Reconstruction midface, LeFort I; three or more pieces,segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
21143	090	19.55

CPT Descriptor Reconstruction midface, LeFort 1; three or more pieces, segment movement in any direction, without bone graft

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	**CPT Code: 21147**	**Key Reference CPT Code: 21151**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	0.00	305.00
Median Immediate Post-service Time	0.00	76.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	90.00
Median Total Time	**0.00**	**471.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.30	4.19
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	4.27
Urgency of medical decision making	2.77	2.88

Technical Skill/Physical Effort (Mean)

Technical skill required	4.74	4 54
Physical effort required	4 26	4.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.44	4.38
Outcome depends on the skill and judgment of physician	4.59	4.50
Estimated risk of malpractice suit with poor outcome	4.48	4.31

.NTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.37	4.38
Intra-Service intensity/complexity	4.63	0.43
Post-Service intensity/complexity	3.63	3.54

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ASPS and AAOMS Consensus Panel recommends the median RVW of 28.13 supported by our survey results. As further support, the Consensus Panel points out the work of 21147 is approximately equivalent to CPT 21143 (work RVW 19.55) plus CPT 20902 (work RVW 7.54), which is 27.09 RVW.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 28% No 72%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 25% I do not agree 75%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) 0% no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 10000%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 21147

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.0	
Number and Level of Office Visits:		**99211:**	
		99212: 0.0	
		99213:	
		99214: 0.0	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:21395 Global Period: 090 Specialty Society RVU: **16.00**
RUC RVU: **13.88**

CPT Descriptor: Open treatment of orbital floor blowout fracture; periorbital approach with bone graft (includes obtaining graft)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18 y.o. male was involved in an altercation and was struck in the face. CT scan of the face reveals a comminuted fracture of the right orbital floor with extensive herniation of orbital fat into the maxilla.

Intraoperatively, the orbital floor fracture is exposed. Because of severe comminution, a bone graft is harvested and used to reconstruct the orbital floor. All incisions are closed primarily.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: ☐ Review pre-operative workup, including: History and Physical examination, consultations from Neurosurgery, Ophthalmology; review laboratory results (CBC, Electrolytes, nutritional parameters), review of CT scans and discussion with radiologist; review of ventilatory status and chest x-ray

☐ Discussion of patient status with Trauma service and with Neurosurgery.
☐ Review planned procedure, incisions. Communicate with operating room regarding needed equipment
☐ Discuss plans with patient, if possible, and patient's family, including incisions, risks, and potential complications Obtain informed consent.
☐ Write pre-operative orders for peri-operative medications, arrange for post-op intensive care unit monitoring if needed.

Pre-service work-- Day of surgery

☐ Confirm that patient is cleared for OR with trauma service.
Change into scrub clothes
☐ Check with lab on blood availability
☐ Discuss length and type of anesthesia with anesthesiologist
☐ Discuss case plan, equipment and supplies needs, positioning with OR nurses and surgical assistants
☐ Review procedure and expected recovery with patient and family
☐ Answer any patient and family questions
☐ Verify antibiotic administration, and prophylaxis for deep venous thrombosis.
☐ Monitor patient positioning, assist as needed in moving patient
☐ Insert Foley Catheter
☐ Place padding on all pressure points, assure head support is appropriate
☐ Shave hair for coronal incision, and/or arrange hair to allow access.
☐ (If tracheostomy being done first by another service, wait on-call until this is done (generally 30-60 minutes)
☐ Prep patient, including scalp, face, intraoral areas
Scrub and gown..

Description of Intra-Service Work: ☐ The lower eyelids are injected with epinephrine, and a waiting period for effect is done. Corneal protectors are inserted on the eyes. Traction sutures are placed on the lower lids. The first side transconjunctival incision is made, and dissection is carried out to the inferior orbital rim and then into the floor of the

orbit. The dissection is carried around to the medial and lateral orbital walls as far as possible to allow definition of the margins of the fracture, including the posterior "shelf" of sphenoid. The soft tissue (ocular muscles and fat) herniated into the maxillary antrum is meticulously dissected free and elevated into the orbit.

☐ The scalp incision is infiltrated with local anesthetic with epinephrine. The incision is made to allow adequate exposure for harvest of a cranial bone graft. The bone graft is marked with a surgical marker. A trough is made cutting down through the outer table of the skull into the diploic space around all four sides of the planned bone graft. An osteotome then is used to cut through the bone in the diploic space and the cortical bone graft is harvested. Hemostasis is obtained at the donor site.

☐ The bone graft is "test fit" into the orbit, and appropriate shaping and reduction of the bone graft is performed until an acceptable shape is obtained to bridge the fracture, maintain reduction of the orbital contents within the orbit, while not creating secondary ocular distortion, such as exophthalmos. Once a satisfactory result is obtained, the bone graft may be secured in place with metallic screw or wire.

☐ At the conclusion of the fixation, The corneal shields are removed. The transconjunctival incisions in each eye are closed with absorbable suture. Forced duction tests are done on each eye to ensure free mobility Medial and/or lateral canthal repairs are done if needed. The scalp incision is closed after removing the Craini clips This closure is done in two layers of galea and skin.

Description of Post-Service Work:

☐ The hair is washed to remove all blood. Sterile head dressings are applied. Antibiotic ointment is placed in the eyes and on all facial lacerations.

☐ The tracheostomy, if necessary, is checked to make sure it is secure. Extubation and post-extubation monitoring are performed, if possible. All tubing is secured, and patient is moved to bed. Patient is moved to recovery room.

☐ Dictate op note

☐ Sign all OR forms, including written op note of pre and post op diagnosis, operations performed, assistants, findings. Communicate with anesthesia personnel for blood loss and fluid administration for notes. Inform OR staff of CPT coding for their records.

☐ Write post op orders for x-rays, medications, IV fluids, ventilator settings, diet, and activities.

☐ Review findings and procedures with Trauma service, and family doctor. Coordinate care.

☐ Discuss findings and procedures with family.

Post op same day work after discharge from recovery:

☐ Examine patient, check wounds, vital signs, and lab work

☐ Review nursing, other staff chart notes

☐ Review findings and treatment with patient when awake.

☐ Answer nursing/ other staff questions

☐ Answer family/patient questions

☐ Review critical care elements including ventilator, heart rate and rhythm, neurology, status of vision and lab tests including CBC, blood gasses

☐ Order next day labs and x-rays, and any other order changes

☐ Chart progress notes

Post-op other hospital work (post op day 1 to discharge)

☐ Examine and talk with patient. Check wounds, vision, neuro status

☐ Extubate or wean from ventilator as required.

☐ Review post reduction films.

☐ Discuss care with trauma, neurosurgery and ophthalmology services

☐ Review nursing and other staff notes.

☐ Review vital signs, I&O, lab work

☐ Answer nursing/other staff questions

Answer patient/family questions

Answer insurance staff questions

Discuss post-discharge disposition with social worker

Discuss rehab needs with Physical Medicine
Write orders for labs, meds, diet, and activity
Chart progress notes
Transfer from ICU as appropriate

Discharge day work:

Examine and talk with patient. Answer questions patient/family
Check final labs/films/tests, discuss results with patient.
Coordinate care with other physicians (Trauma, Rehab, Neurosurgery, Ophthalmology)
Answer nursing/other staff questions
Answer insurance questions
Answer rehab facility questions
Write orders for post-discharge tests
Write prescriptions for medications
Chart discharge note
Dictate discharge summary

Post op office work:

Examine and talk with patient
Check wounds, remove sutures, check IMF and adjust wires if needed.
Answer patient/family questions
Monitor rehab, review records from rehab facility.
Discuss patient with referring and consulting physicians. (verbal and written)
Coordinate care with other physicians.
Discuss patient with insurance nurses or medical directors.
Write prescriptions for medications
Review post discharge labs and films
Fill out paperwork for insurance, disability, work excuses, visiting nurse, etc.
Discuss progress and plans with patient/family.
☐ Write patient progress note.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Keith Brandt, MD, and Robert Havlik, MD					
Specialty(s):	ASPS, ASMS					
CPT Code:	21395					
Sample Size:	127	**Resp n:** 15		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		5.00	14.00	**16.00**	18.00	22.43
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**15.0**		
re-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		60.00	90.00	**120.00**	165 00	240 00
Post-Service	**Total Min****	**CPT code / # of visits**				

Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**49.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**38.0**	99211x **0.0** 12x **1.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
21390	090	10.11

CPT Descriptor Open treatment of orbital floor blowout fracture; periorbital approach, with alloplastic or other implant

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
20902	090	7.54

CPT Descriptor Bone graft, any donor area; major or large

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 46.6 %

TIME ESTIMATES (Median)	**CPT Code: 21395**	**Key Reference CPT Code: 21390**
Median Pre-Service Time	60.00	0.00
Median Intra-Service Time	120.00	0 00
Median Immediate Post-service Time	30.00	0 00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	0.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	38.0	0.00
Median Total Time	**333.00**	**0.00**
		333.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.22	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.40
Urgency of medical decision making	2.44	3 60

Technical Skill/Physical Effort (Mean)

Technical skill required	3.14	4.10
Physical effort required	3.36	3.30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	3.50
Outcome depends on the skill and judgment of physician	4.21	3 90
Estimated risk of malpractice suit with poor outcome	3 57	3.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.08	3.86
Intra-Service intensity/complexity	3.69	4.07
Post-Service intensity/complexity	2.92	4.14

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ASPS and ASMS Consensus Panel recommends the median RVW of 16.00 supported by our survey results. As further support, the Consensus Panel points out the work of 21395 is approximately equivalent to the work of CPT 21390 - open treatment of orbital floor fracture with alloplastic implant (work RVW 10.11) plus CPT 20902 - bone graft harvest (work RVW 7.54). These two codes combine for a total of 17.65 RVWs which compares favorably with the requested survey median RVW of 16.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 19% No 81%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 33% less complex (less work) 0% no change 67%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 21395 NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 2.0	
		99213: 1.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 1.0	
		99214:	
		99215:	

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

RUC 2 – ORTHOPAEDIC SURGERY

RUC RECOMMENDATIONS

The American Academy of Orthopaedic Surgery, The Musculoskeletal Tumor Society, the Orthopaedic Trauma Association, The American Society of Shoulder and Elbow Surgeons, The American Society for Surgery of the Hand, and the American Society of Hip and Knee Surgeons made presentations to the RUC for codes that were identified as misvalued due to changes in the patient population, rank order anomalies, and due to CMS submission.

The American Academy of Orthopaedic Surgery and the Musculoskeletal Tumor Society presented three families of tumor procedures.

Family 1: Excision of Deep Soft Tissue Mass (23076, 27328, 21556, 24076, 25076, 27048, 27619, 28045)
Family 2: Radical Resection of Soft Tissue Sarcoma (24077, 27329, 25077, 27049, 27615)
Family 3: Radical Resection of Bone Sarcoma (23220, 27365, 23200, 23210, 24150, 24152, 25170, 27076, 27078, 27645, 27646, 27647)

For all three families the specialties utilized a mini survey methodology. The RUC reviewed the methodology and expressed concern that some of the codes may not have met the previous RUC standard of low volume at less than 1,000 cases per year of Medicare volume. The presenters stated that many of these procedures are evenly distributed across the non-Medicare population so the total volume is higher than the Medicare volume. However, the RUC agreed to review the data as the RUC has never defined "low volume" for purposes of mini-surveys.

The presenters made the following case for compelling evidence to change the relative values of the tumor codes.

During the past 10 years, significant advancement has been made in the treatment of bone and soft tissue tumors. Imaging advances have allowed for much more precise understanding of anatomic location and extent of tissue involvement. For malignant tumors of bone and soft tissue, adjuvant treatments such as radiation therapy and chemotherapy have advanced greatly. This has enhanced our ability to kill tumors in situ at a higher level. While 20 years ago amputation was used most commonly, limb preservation resections have now become the rule with amputation being used in less than 5% of patients with pelvic and extremity sarcomas.

As such, whereas in the past only small lesions were amenable to resection, now very large tumors are routinely resected thereby sparing these patients the disfigurement and functional issues associated with amputation. The work associated with soft tissue and bone resection procedures has increased as the magnitude of what is possible has increased dramatically. These procedures are more technically demanding, prolonged, and involve more risk. These deep tumors of bone and soft tissue are typically asymptomatic, and therefore attain large size before coming to attention. Resecting these lesions with a wide margin in adjacent tissues routinely requires meticulous dissection around major nerves and blood vessels.

The excision of deep benign masses (e.g. desmoid tumors, hemangiomas, infiltrating lipomas and neural tumors) has also advanced in light of superior imaging and adjuvant treatments such as embolization, low dose chemotherapy etc. Again, these deep seated tumors are typically large at the time of initial presentation. Many lesions which were previously thought to be unresectable have increasingly been treated with surgical excision to the benefit of patients.

Family 1: Excision of Deep Soft Tissue Mass (23076, 27328, 21556, 24076, 25076, 27048, 27619, 28045)
The RUC examined the survey results and concluded that the survey data did not reflect the typical patient as identified in the Medicare data. Because the survey results described a hospitalized patient but the Medicare data indicate that only 7% to at the most 37% of patients receiving these procedures are hospitalized. Therefore, the RUC determined that the survey data could not be used and determined that there were two distinct patient populations being reported with these codes. This is most likely due to ambiguous CPT descriptors. Therefore based on the survey data and the Medicare data and absent any compelling evidence data from the presenters the RUC recommended referring the codes to CPT for clarification of "deep" excision and possibly creating new codes to differentiate based on the size and depth of the tumor.

Family 2: Radical Resection of Soft Tissue Sarcoma (24077, 27329, 25077, 27049, 27615)
The RUC found the same inconsistencies between the survey data and the Medicare data in that the survey data describes a hospitalized patient but the Medicare data indicate that only codes 27329 and 27049 have more than 50% of patients treated as inpatients. The RUC decided to refer this family to CPT for clarification.

Family 3: Radical Resection of Bone Sarcoma (23220, 27365, 23200, 23210, 24150, 24152, 25170, 27076, 27078, 27645, 27646, 27647)
The RUC examined this family of codes as an entire family. The RUC discussion focused on the issue of whether there may be different patient populations covered by each of these codes as was the case for tumor families 1 and 2 that were referred to CPT for additional clarification. If there are different populations, the RUC examined whether this warranted the creation of additional codes to differentiate superficial and malignant procedures. The RUC discussed this issue in detail and although all of these codes are predominantly performed in the inpatient setting according to Medicare data, the workgroup felt that additional clarification of the codes was warranted. The RUC suggested that the codes may need to be differentiated between malignant and benign or by the size of the tumor. The workgroup also strongly recommends that all appropriate specialty societies participate in the code development process. This recommendation was supported by the presenting specialty society.

For code 27647 the RUC requested to examine the AAOS and APMA data separately since podiatry performs 56 percent of the procedure. The RUC examined the survey data and determined that there was no compelling evidence to change the value of this procedure. Based on Medicare data, podiatry is the typical provider of this service and an examination of the podiatry survey data resulted in a median RVU of 12.78 with significantly lower intra-service time, therefore there was not sufficient evidence to increase the value to the requested RVU of 20.00. Additionally the RUC was concerned that the APMA data was based on a mini-survey that did not include an anchor code and a full RUC survey. Also, the RUC was not convinced that the size of the typical tumor has changed for this procedure.

Trauma (20680, 20692, 24430, 27465, 27470, 27472, 27709, 27720)
The RUC agreed that these codes should be examined for potential rank order anomalies. The RUC was concerned that code 20692 is a modifier 51 exempt code and codes 27472 and 27720 have values based on the value of 20902 *Bone graft, any donor area; major or large.* These are all codes with 90 day global periods, therefore codes 20692, 27472, and 27720 are being referred to CPT to obtain a

rational for why codes with 90 day global periods that have pre and post service times are modifier 51 exempt. The RUC was concerned that attempting to value these three codes would lead to double counting of some work.

Total Elbow (24363) and General (20600, 20610, 29075)
CMS submitted codes 20600, 20610, and 29075 because the codes have never been reviewed by the RUC. The RUC rejected the recommended RVUs for all of these codes and for code 24363 the value was set equal to code 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))* (RVW = 21.07), and the RUC agreed to maintain the current values of all the general orthopedic codes.

Wrist, Hand, Finger (25447, 26055, 26160, 26600, 26951, 64702, 64721)
Standard RUC surveys were conducted for each code and in some cases the RUC recommends increasing the current value to correct rank order anomalies. In other cases the new survey time was felt to be more accurate than the Harvard times, but the recommended increase in work RVUs were not accepted by the RUC. All but code 64702 were submitted by CMS because the codes had never been reviewed by the RUC.

Total Joint and Hip Fracture (27130, 27447, 27236)
These three codes were placed in the five-year review by CMS. The RUC workgroup reviewed these codes in August and assigned action key 2, No Change, because the specialty developed its recommendations based solely on NSQIP data and a Medicare DRG database. The specialty conducted a survey but concluded that it was faulty because the vignettes did not describe a typical patient. The specialty did not provide this survey data to the workgroup. The workgroup then requested the specialty to conduct a survey for the September RUC meeting with the understanding that the workgroup chair would extract the codes.

The specialties presented recommendations primarily based on survey data, however, the recommendations were supplemented by NSQIP and data for intra-service time. In addition the specialties then compared the codes with other RUC reviewed codes to show that the recommended values and times placed the codes in proper rank order.

The RUC began its review by reducing the preservice times for all three codes. The workgroup then discussed in detail the use of survey intra-service time as opposed to NSQIP time. For example, code 27130 has 135 minutes of NSQIP intra-service time as opposed to 110 minutes based on the survey. The specialties stated that the survey intra-service time of 110 minutes did not fully capture all of the intra-service time and

compared this time to NSQIP time of 135 minutes and a CMS DRG time of 144 minutes. The specialty explained that their methodology was to use the surveyed number and level of hospital visits when that survey derived length of stay equaled the NSQIP length of stay. This was used for codes 27130 and 27447. For 27236 the specialty chose to assign a number and level of visits based on the NSQIP length of stay because the specialty felt that the NSQIP length of stay was in proper rank order in comparison to the other two codes under review and the survey underestimated the visits.

The RUC discussed whether the NSQIP intra-service time should be used instead of the survey data and agreed for these three codes to use NSQIP intra-service times, recognizing that for codes 27130 and 27447 the NSQIP time is higher and for code 27236 the NSQIP time is lower. For code 27236 the specialty recommended using the NSQIP length of stay of six days as opposed to the imputed survey derived length of stay of five days. Other that these exceptions for intra-service time and length of stay for 27236, all other time data is based on the survey.

Some RUC members were uncomfortable with mixing NSQIP and survey data as opposed to using only survey data, but the specialty explained that the NSQIP intra-service time was felt to be more valid and also consistent with the DRG database. Additionally for codes 27130 and 27447 the survey imputed length of stay matched the NSQIP length of stay data so the survey hospital visit data was felt to be validated by NSQIP. For 27236 the NSQIP length of stay data was used because it placed the hospital visit data in proper rank order. Also, the specialties stated that the NSQIP intra-service time was more consistent among the three codes as the survey intra-service times were inconsistent. For example, the survey intra-service time for 27236 was 120 minutes and 27130 was 110 minutes. According to the presenters the relationship between the two codes are exactly the opposite and 27236 should have a higher intra-service time and the survey times were flawed. Therefore to preserve proper rank order in intra-service time, the workgroup recommends using the NSQIP derived intra-service times for all three codes. Additionally, the workgroup examined the IWPUT values based on these times and felt that resulting intensities supported using these times.

The RUC also compared the specialty recommendation with the existing Harvard times. The survey data suggests a decrease in length of stay for each of the codes but the presenters argued that although there are now fewer hospital visits, the total amount of work has not changed because the hospital and office visits are at a higher level and are more intense since the patients are discharged earlier. The presenters also questioned whether the CMS assigned number and level of post-service visits were accurate.

Based on a review of the survey data and the NSQIP data for intra-service time as well as a comparison to other reference codes, the workgroup did not see any compelling evidence for changing the current work RVUs. The RUC did agree to maintain the current work relative values but to accept the new physician times.

AMA/Specialty Society RVS Update Committee
RBRVS 2005 Five-Year Review
RUC Recommendations - Orthopaedic Surgery

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
20600	Drain/inject, joint/bursa	0 66	0 66	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The workgroup reviewed the survey data from 30 respondents and were uncomfortable changing the value of such a high volume procedure that had only the minimum number of respondents. In addition the presenters were unable to present any compelling evidence for changing the value. The workgroup recommends maintaining the current value and not accepting the new survey times.		2
20610	Drain/inject, joint/bursa	0 79	0 79	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The workgroup reviewed the survey data from 30 respondents and were uncomfortable changing the value of such a high volume procedure that had only the minimum number of respondents. In addition the presenters were unable to present any compelling evidence for changing the value. The workgroup recommends maintaining the current value and not accepting the new survey times.		2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
20680	Removal of support implant	3 34	5 86	AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs· 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure.	The workgroup reviewed the compelling evidence, which was developed by a specialty society expert panel for 20680 removal of implant, deep (eg, buried wire, pin, screw, metal band, nail, rod or plate). The panel noted there have been significant changes in physician work with respect to the removal of deep implants due to changes in technology 10 years ago, conventional hardware removal involved open removal of plate and screws under direct visualization. Modern minimally invasive hardware often involves "fishing" for buried hardware through small incisions under fluoroscopic control. Furthermore, it is not uncommon for hardware to become overgrown with bone, which requires considerable bone removal with osteotomes or a power burr to unroof the hardware The workgroup agreed that these reasons provide compelling evidence that suggest the intra-operative time and RVW for 20680 is misvalued. The workgroup also agreed that the 25th percentile value of 6 50 was appropriate along with the 25th percentile intra-service time of 50 minutes but since the procedure is typically performed in an outpatient setting, a half of a 99238 was deducted from the value for a final RVU of 5.86	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
20692	Apply bone fixation device	6.40		AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure	The specialty societies were recommending that this code have two hospital visits and six office visits, but it was also explained that code is typically performed with other procedures Although the code is performed with other procedures it is still a 90 day global period but it is modifier 51 exempt The workgroup was concerned that the modifier 51 exemption for this code would led to double counting of the pre and post operative work since if done as a multiple procedure, its value would not be reduced. The workgroup recommends referral to CPT to clarify the inclusion of 90 day global period codes as being modifier 51 exempt The CPT representatives attending the workgroup indicated that this could be included in Copt's overall review of modifiers.	☐	5
21556	Remove lesion neck/chest	5.56		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The workgroup recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
21935	Remove tumor, back	17.93		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	Specialty withdrew code from five-year review.	☐	7
23076	Removal of shoulder lesion	7.62		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The workgroup recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5
23200	Removal of collar bone	12.06		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
23210	Removal of shoulder blade	12 47		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures.	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5
23220	Partial removal of humerus	14 54		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
23515	Treat clavicle fracture	7 40		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5
23585	Treat scapula fracture	8 95		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
23615	Treat humerus fracture	9 34		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5
23616	Treat humerus fracture	21 24		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
23630	Treat humerus fracture	7 34		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5
23670	Treat dislocation/fracture	7.89		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
23680	Treat dislocation/fracture	10.04		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5
24076	Remove arm/elbow lesion	6.29		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The workgroup recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
24077	Remove tumor of arm, elbow	11.74		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5
24150	Extensive humerus surgery	13 25		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5
24151	Extensive humerus surgery	15 56		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	Specialty withdrew code from five-year review.	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
24152	Extensive radius surgery	10 04		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5
24153	Extensive radius surgery	11 52		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures.	Specialty withdrew code from five-year review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
24363	Replace elbow joint	18 46	21 07	AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs: 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure	The workgroup reviewed the compelling evidence for 24363 Arthroplasty, elbow, with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow) The presenters stated there have been changes in physician work with respect to total elbow arthroplasty In addition, there is an anomalous relationship between 24363 (RVW = 18 46) and 23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) (RVW = 21 07) The presenters stated that the physician work for these procedures are almost equivalent The workgroup reviewed the survey time and visit data for 24363 and was concerned that 24363 had 15 minutes less intra-service time than the reference code 24372 Although 24363 has 15 minutes less intra-service time the presenters that that this is a more complex procedure than the reference. Specifically, the presenters stated that there is more psychological stress with a fairly complicated procedure that is performed infrequently total elbow replacement (TER) - concern for poor outcome and patient dissatisfaction. There are more neurovascular structures are closer to bone at the elbow than at the shoulder, leading to a potentially higher risk for injury (e.g , ulnar nerve injury) and TER requires neuroplasty of the ulnar nerve (i e., decompression and anterior transposition). The axillary nerve in TSR surgery is often identified, but is typically not decompressed Also the presenters provided a rationale why the pre-service time for TER at 83 minutes is higher than in TSR TER less familiar than TSR Many orthopedic surgeons are accustomed to performing a shoulder hemi-arthroplasty procedure (i e., prosthetic humeral head replacement) for treatment of proximal humerus fractures and shoulder arthritis Concurrent resurfacing of the glenoid constitutes a TSR Elbow fractures and elbow arthritis are less frequently treated by joint replacement surgery More time is inherently involved in preparing for the technical aspects of a TER (exposure and use of instrumentation) Discussion with the patient and family regarding the risks and benefits of surgery More time is involved in discussing a procedure (TER) that is performed infrequently OR staff often unaccustomed to	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
					TER instrumentation and implants More time is necessary to coordinate OR staff and surgical assistants) with the planned operation Instrumentation and implants for a TER are usually not available in-house Time is necessary to coordinate the vendor for delivery of the equipment and implants The workgroup accepted the presenters rationale and concluded that code 24363 should be valued the same as code 23472 To maintain appropriate rank-order alignment with 23472, the expert panel recommends the value of 21 07		
24430	Repair of humerus	12.79	14.00	AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure	The workgroup examined the compelling evidence presented by the specialty societies for code 24430 Repair of nonunion or malunion, humerus, without graft (eg, compression technique) The presenters noted an anomalous relationship exists between 24430 (RVW = 12.79) and 24515 Open treatment of humeral shaft fracture with plate/screws, with or without cerclage (RVW = 11.63, intra time 106 minutes) 24430 is more complex than 24515 because the typical patient for 24430 presents with prior scarring from injury and/or surgery. As a result 24430 does not account for all the work typically involved The workgroup reviewed the survey time and visit data for 24430 and concluded that the intra-service time and RVU should be the 25th percentile at 14 RVUs and 102 minutes The remaining times and visits were appropriate	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
24545	Treat humerus fracture	10 44		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
24546	Treat humerus fracture	15.67		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
24575	Treat humerus fracture	10.64		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5
24579	Treat humerus fracture	11.58		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
24635	Treat elbow fracture	13	17	AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5
24665	Treat radius fracture	8	13	AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
24685	Treat ulnar fracture	8.79		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
25076	Removal forearm lesion deep	4 91		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The workgroup recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
25077	Remove tumor, forearm/wrist	9.75		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures.	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor		5
25170	Extensive forearm surgery	11 07		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures.	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor		5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
25447	Repair wrist joint(s)	10.35	10.35	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The workgroup reviewed the survey data and agreed that the median survey value of 10 75 supported maintaining the current value of 10 35 Both the 25th and 75th percentile values were close to the median value indicating additional support that the current value is appropriate The workgroup recommends maintaining the current value as there was no compelling evidence to change the value, however the workgroup recommends accepting the new survey times since the Harvard time may have been developed by extrapolation and not by survey	☑	2
25515	Treat fracture of radius	9 17		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
25526	Treat fracture of radius	12 96		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5
25545	Treat fracture of ulna	8 89		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
25574	Treat fracture radius & ulna	7 00		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
25575	Treat fracture radius/ulna	10 43		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
25620	Treat fracture radius/ulna	8.54		ASSH commented that the code is based on Harvard time and visit data that ASSH believes are not accurate AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	ASSH has requested to delete this code and replce it with three new codes This proposal was reviewed at the October 2005 CPT meeting and the RUC will review as part of the CPT 2007 cycle	☐	5
25620	Treat fracture radius/ulna	8 54		ASSH commented that the code is based on Harvard time and visit data that ASSH believes are not accurate AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	ASSH has requested to delete this code and replce it with three new codes This proposal was reviewed at the October 2005 CPT meeting and the RUC will review as part of the CPT 2007 cycle	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
25628	Treat wrist bone fracture	8 42		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
26055	Incise finger tendon sheath	2 69	2 69	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The workgroup determined that there was no compelling evidence for increasing the value of this procedure as recommended by the presenters. The workgroup recommends maintaining the current value as there was no compelling evidence to change the value, however the workgroup recommends accepting the new survey times since they were believed to be more accurate than the Harvard times	☑	2
26160	Remove tendon sheath lesion	3 15	3 15	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The workgroup determined that here was no compelling evidence for increasing the value of this procedure as recommended by the presenters. The workgroup recommends maintaining the current value as there was no compelling evidence to change the value, however the workgroup recommends accepting the new survey times since they were believed to be more accurate than the Harvard times	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
26600	Treat metacarpal fracture	1.96	2.40	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The workgroup examined the data presented by the specialty society and agreed that the current value may not fully reflect the value of all post operative office visits that are the current standard of care. Even though CPT 26720 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, without manipulation, each was cited most often as a reference for 26600 Closed treatment of metacarpal fracture, single, without manipulation, each bone the presenters stated that 26720 does not include accurate data in the Harvard data Specifically, the number of post-op visits is understated Each level 2 office visit (RVW of 0 45) represents 25% of the total RVW for this 26720 The specialty society expert panel analyzed the current RVW (1 96) with the current survey data. The result was a negative IWPUT (-0 005) The survey median RVW of 2 40 results in an IWPUT of 0.024, which is less than an E/M service and similar to the IWPUT that Harvard assigned to the evaluation, positioning, and immediate post-time components Because the intra-service work is very similar to the immediate post-service work of applying dressings, the presenters stated that the survey median represents a reasonable value for this code. The workgroup agreed with the presenters and validated the survey median value of 2 40 by performing a building block calculation by adding the value of an additional 99212 (43) to the current value of 1.96 for a total value of 2 39 Since this value was almost identical to the median survey value the workgroup recommends accepting the median survey value of 2.40 RVUs.	☑	1

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
26615	Treat metacarpal fracture	5 32		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
26665	Treat thumb fracture	7.59		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
26685	Treat hand dislocation	6 97		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
26715	Treat knuckle dislocation	5 73		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
26735	Treat finger fracture, each	5 97		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5
26746	Treat finger fracture, each	5 80		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
26765	Treat finger fracture, each	4 16		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
26785	Treat finger dislocation	4.20		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
26951	Amputation of finger/thumb	4 58	5.25	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The workgroup agreed that this code is a rank order anomaly when compared to reference code CPT 26185 Sesamoidectomy, thumb or finger (separate procedure). Intra-operative work (time and intensity) is similar for both procedures, which involve dissection of neurovascular structures. The Harvard pre-service time is low compared with other hand surgery codes No time was allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder Pre-service and post-service facility work will be identical 26951 includes one more office visit than 26185 The extra visit stems from the fact that digits which undergo amputation have often been traumatized and have compromised soft tissues that require closer monitoring than would a non-traumatized digit undergoing a sesamoidectomy. Additionally, amputated digits frequently develop post- amputation hypersensitivity that requires prolonged monitoring of the desensitization process. The workgroup agreed that the code is undervalued and therefore agreed that he 25th percentile value of 5.25 placed the code in proper rank order Also the median intraservice time of 45 minutes should be used since that is equal t the reference code	☑	4
27048	Remove hip/pelvis lesion	6 24		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The workgroup recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27049	Remove tumor, hip/pelvis	13 64		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures.	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5
27076	Extensive hip surgery	22 09		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures.	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5
27078	Extensive hip surgery	13.42		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27130	Total hip arthroplasty	20.09	20.09	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC did not find any compelling evidence to change the current work RVU. Based on the survey data the RUC agreed to maintain the current value but use the new physician time data.	☑	2
27236	Treat thigh fracture	15 58	15 58	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC did not find any compelling evidence to change the current work RVU Based on the survey data the RUC agreed to maintain the current value but use the new physician time data.	☑	2
27248	Treat thigh fracture	10 43		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27328	Removal of thigh lesion	5.56		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures.	The workgroup recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5
27329	Remove tumor, thigh/knee	14.12		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5
27365	Extensive leg surgery	16 25		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27447	Total knee arthroplasty	21 45	21 45	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC did not find any compelling evidence to change the current work RVU. Based on the survey data the RUC agreed to maintain the current value but use the new physician time data	☑	2
27465	Shortening of thigh bone	13.85	17 50	AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs: 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure	The workgroup reviewed the compelling evidence for 27465 Osteoplasty, femur; shortening (excluding 64876). They noted an anomalous relationship exists between 27465 (RVW = 13 85) and 27506 Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws (RVW = 17.42) 27465 typically includes the insertion of an intramedullary nail. As a result, the current RVW of 27465 does not fully account for the work typically involved in shortening a femur The workgroup however was concerned that in comparison with the reference code 27454 Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure) (work RVU, 17 53, intra time of 150 minutes) , that the code should be valued lower than this reference code The presenters stated that 27465 is a higher intensity procedure and the survey respondents did not rate it as having a higher intensity than 27454 because they may not be familiar with the reference procedure The workgroup reviewed the survey time and visit data for 27465 and concluded that the pre-, intra-, and post-service times are appropriate as are the number and intensity of post-operative hospital (99231x3, 99238x1) and office (99213x2, 99212x2) visits. The workgroup agreed to the median value based on a rank order anomaly with code 27506	☑	1

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27470	Repair of thigh	16.05	16 05	AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure	The workgroup believes there is not compelling evidence to change the work value and recommends maintaining the existing RVW of 16 05 for 27470. However, the workgroup recommends using the new survey times as the Harvard times are inflated	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27472	Repair/graft of thgh	17 69		AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs: 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure	The workgroup reviewed the compelling evidence for 27472 Repair, nonunion or malunion, femur, distal to head and neck, with iliac or other autogenous bone graft (includes obtaining graft) They noted an anomalous relationship exists between 27472 (RVW = 17 69) and 27506 Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws (RVW = 17 42) 27472 is typically more complex than 27506 because correction of a deformity is in an altered surgical field, and typically a bone graft is harvested from a distant site (20902 Bone graft, any donor area, major or large (RVW = 7.54)). As a result, 27472 does not account for all the work involved. The presenters recommended that, in order to maintain appropriate relativity between 27470 and 27472, it is warranted to increase the value of 27472 so it includes the value of the base code (27470 = 16 05 RVW) and 50% of the work for obtaining a bone graft (20902 = 7.54 RVW) This additional 3.77 RVW will account for the work of harvesting a graft from a distant site. The presenters recommended a RVW of 19.82 (16 05 + 3 77 = 19 82) for 27472, but the workgroup felt that the post-operative visits should be reduce by one 99231(64) and one 99213 (65) for a final RVU of 18 53 However the workgroup concluded that this code should be referred to CPT because code 20902 is a modifier 51 exempt code but has post service time included in the value therefore the workgroup was unsure what percentage of 20902 should be added to 27472	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27511	Treatment of thigh fracture	13 62		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
27513	Treatment of thigh fracture	17 89		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27514	Treatment of thigh fracture	17 27		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
27519	Treat thigh fx growth plate	15 00		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27535	Treat knee fracture	11 48		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
27540	Treat knee fracture	13.08		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27556	Treat knee dislocation	14.39		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
27615	Removel tumor, lower leg	12.54		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27619	Remove lower leg lesion	8.39		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The workgroup recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5
27645	Extensive lower leg surgery	14.15		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5
27646	Extensive lower leg surgery	12.64		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The RUC recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27647	Extensive ankle/heel surgery	12.22	20 00	The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The workgroup determined that there was no compelling evidence to change the value of this procedure. Based on Medicare data, podiatry is the typical provider of this service and an examination of the podiatry survey data resulted in a median RVU of 12 78with significantly lower intraservice time, therefore there was not sufficient evidence to increase the value to the requested RVU of 20 00 Additionally the workgroup was concerned that the APMA data was based on a mini-survey that did not include an anchor code and a full RUC survey. Also, the workgroup was not convinced that the size of the typical tumor has changed for this procedure	☐	5
27709	Incision of tibia and fibula	9 94	16 50	AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure	The workgroup reviewed the compelling evidence for 27709 Osteotomy, tibia and fibula They noted 27709 (RVW = 9 93) is a rank-order anomaly when compared to 27705 Osteotomy; tibia (RVW = 10.36). The workgroup reviewed the survey time and visit data for 27709 and agreed that the pre-, and post-service times are appropriate as well as the number and intensity of post-operative hospital (99231x2, 99238x1) and office (99213x2, 99212x2) visits The workgroup, however, determined that a more appropriate ranking order would be to use the 25th percentile intra-service time and RVU of 16 50 as this would place the code in proper rank order with 27705	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27720	Repair of tibia	11 77		AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs: 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure.	The workgroup attempted to value the code by comparing the code to 27724 Repair of nonunion or malunion, tibia, with iliac or other autograft (includes obtaining graft) (work RVU, 18 17) and then backing out half the value of the graft code 20902 Bone graft, any donor area; major or large (work RVU, 7 54) However since 20972 is a modifier 51 exempt code the workgroup recommends referring this code to CPT to clarify the definition of modifier 51 exempt codes if they are 90 day global procedures The workgroup concluded that this code should be referred to CPT because code 20902 is a modifier 51 exempt code but has post service time included in the value therefore the workgroup was unsure what percentage of 20902 should be added to 27720	☐	5
27766	Treatment of ankle fracture	8 35		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27784	Treatment of fibula fracture	7.10		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
27792	Treatment of ankle fracture	7 65		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27814	Treatment of ankle fracture	10 66		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5
27822	Treatment of ankle fracture	10 98		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27826	Treat lower leg fracture	8 53		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27827	Treat lower leg fracture	14 04		AAOS commented that one or more of the following compelling evidence arguments is applicable for increasing the work RVUs: 1) an anomalous relationship exists between the musculoskeletal procedure and other musculoskeletal procedures, 2) there is evidence that Harvard study data was flawed, and/or 3) technique and technology have changed physician work for the procedure AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27828	Treat lower leg fracture	16 21		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
27829	Treat lower leg joint	5.48		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
27832	Treat lower leg dislocation	6 48		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
28045	Excision of foot lesion	4 71		The AAOS commented that the RVUs of the musculoskeletal tumor procedures is based on Harvard study data that AAOS believes is flawed. For all the identified musculoskeletal tumor procedures, the Harvard data significantly underestimates the intra-service time and therefore the IWPUT is low compared to other musculoskeletal procedures	The workgroup recommends referring the code to CPT for clarification of deep excision and possibly creating new codes to differentiate based on the size and depth of the tumor.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
28415	Treat heel fracture	15 95		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
28445	Treat ankle fracture	15.60		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
28465	Treat mid foot fracture, each	7 00		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
28485	Treat metatarsal fracture	5.70		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
28505	Treat big toe fracture	3 80		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5
28525	Treat toe fracture	3 32		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
28555	Repair foot dislocation	6 29		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
28585	Repair foot dislocation	7.98		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
28615	Repair foot dislocation	7 76		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation		5
28645	Repair toe dislocation	4 21		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor. In particular, the CPT descriptor states "with or without internal or external fixation " However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site.	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation.		5

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Action Key (1 = Adopt the recommended increase in the work RVU, 2 = Maintain the current work RVU, 3 = Adopt the recommended decrease in the work RVU, 4 = Suggest a new RVU; 5 = Refer the code to CPT, 6 = No consensus, 7 = Accept withdrawal by commenter, without prejudice, 8 = No Level of Interest submitted, no Recommendation submitted)

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
28675	Repair toe dislocation	2.92		AAOS commented that the compelling evidence rationale for examining the work RVU is that there is evidence that incorrect assumptions were made in the valuation of the code due to lack of clarity of the CPT descriptor In particular, the CPT descriptor states "with or without internal or external fixation." However, it is unclear whether the previous valuation for the code includes the situation when internal and external fixation is applied to a fracture site	The specialty has submitted the code to CPT to clarify the descriptor for 57 fracture treatment codes that contain the term with or without internal or external fixation	☐	5
29075	Application of forearm cast	0.77	0 77	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The workgroup reviewed the survey data from 30 respondents and were uncomfortable changing the value of such a high volume procedure that had only the minimum number of respondents In addition the presenters were unable to present any compelling evidence for changing the value The workgroup recommends maintaining the current value and not accepting the new survey times	☐	2

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Action Key (1 = Adopt the recommended increase in the work RVU, 2 = Maintain the current work RVU, 3 = Adopt the recommended decrease in the work RVU, 4 = Suggest a new RVU, 5 = Refer the code to CPT, 6 = No consensus, 7 = Accept withdrawal by commenter, without prejudice, 8 = No Level of Interest submitted, no Recommendation submitted)

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
64702	Revise finger/toe nerve	4.22	5 52	ASSH reported that the code is based on Harvard data, which ASSH believes are not accurate. Specifically , the times are low compared to other hand surgery codes.	The RVW for code 64702 Neuroplasty, digital, one or both, same digit is based on Harvard time and visit data, which the presenters stated is inaccurate The Harvard pre-service time is low compared with other hand surgery codes No time was allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder. Additionally, only two postoperative office visits are included in the database, which is significantly less than the typical four or more visits necessary. This procedure is typically performed in an outpatient setting, requiring return of the patient to the surgeon's office within a few days of the surgery for a wound check, dressing change, and referral to occupational therapy. The second office visit is typically for suture removal, wound check, and assessment of therapy requirements. The remaining office visits include assessment of nerve healing and range of motion Code 64704 Neuroplasty; nerve of hand or foot was cited most often as a reference for 64702 Intra-operative work (time and intensity) according to the presenters is similar for both procedures, which involve dissection of neurovascular structures Pre-service and post-service facility work will be similar. The workgroup felt that the current value of 4.22 plus the two additional 99213 (1 3) produces a proper value of 5.52 and place the code in proper rank order with the reference service	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
64721	Carpal tunnel surgery	4.28	4 28	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The workgroup determined that here was no compelling evidence for increasing the value of this procedure as recommended by the presenters The workgroup recommends maintaining the current value as there was no compelling evidence to change the value, however the workgroup recommends accepting the new survey times since they were believed to be more accurate than the Harvard times	☑	2

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		BBM intensity ->							0 0224	0 0224	0 0081		0 0224	3 99	2 00	1 51	1 06	0 64	1 28	1 75	1 73	1 08	0 65	0 43	0 17
		RUC time ->												60	30	41	30	19	36	45	59	38	23	15	7
					Total	HOSP	OFF	Tot PRE	PRE			INTRA	POST-HOSPITAL								POST-OFFICE				
	CPT	DESCRIPTOR	IWPUT	RVW	time	visit	visit	time	EVAL	POSIT	SDW	MED	P-SD	91	92	33	32	31	38	39	15	14	13	12	11
HIP PROCEDURES																									
RUC	27134	Revision of total hip arthroplasty, both components, with or without autograft	0.074	28.48	608	8.0	3 0	90		90		240	40					7	1				3		
RUC	27151	Osteotomy, iliac, acetabular or innominate bone, with femoral	0.066	22.48	518	4 0	4 0	83		83		210	40					3	1				4		
RUC	27259	Open treatment of spontaneous hip dislocation (developmental, including	0.060	21.52	530	4 0	4 0	90		90		210	30					3	1			1	3		
RUC	27147	Osteotomy, iliac, acetabular or innominate bone, with open reduction	0.070	20.55	469	3 0	4 0	83		83		180	40					2	1				4		
AAOS	**27130**	**Arthroplasty, acetabular and proximal femoral prosthetic**	**0.081**	**20.09**	**462**	**5.0**	**4.0**	**90**	**60**	**15**	**15**	**135**	**30**				**1**	**3**	**1**				**3**	**1**	
AAOS	**27236**	**Open treatment of femoral fracture, proximal end, neck, internal fixation**	**0.060**	**15.58**	**447**	**6.0**	**4.0**	**90**	**60**	**15**	**15**	**90**	**30**				**2**	**3**	**1**				**3**	**1**	
RUC	27036	Capsulectomy or capsulotomy, hip, with or without excision of heterotopic	0.047	12.86	376	3 0	4 0	60		60		120	30					2	1				4		
KNEE PROCEDURES																									
RUC	27487	Revision of total knee arthroplasty, with or without allograft, femoral and	0.081	25.23	513	6 0	4.0	60		60		200	30					5	1				4		
AAOS	**27447**	**Arthroplasty, knee, condyle and plateau; medial AND lateral**	**0.099**	**21.45**	**451**	**5.0**	**4.0**	**75**	**45**	**15**	**15**	**124**	**30**				**1**	**3**	**1**			**1**	**2**	**1**	
RUC	27580	Arthrodesis, knee, any technique	0 073	19 34	444	5 0	4 0	60		60		150	30					4	1				4		
RUC	27486	Revision of total knee arthroplasty, with or without allograft, one	0.068	19 24	463	6 0	4.0	60		60		150	30					5	1				4		
TOTAL JOINT PROCEDURES																									
AAOS	**27447**	**Arthroplasty, knee, condyle and plateau; medial AND lateral**	**0.099**	**21.45**	**451**	**5.0**	**4.0**	**75**	**45**	**15**	**15**	**124**	**30**				**1**	**3**	**1**			**1**	**2**	**1**	
RUC	23472	Arthroplasty, glenohumeral joint, total shoulder (glenoid and proximal	0 079	21.07	443	4 0	4 0	60		60		165	30				1	2	1				3	1	
AAOS	24363	Arthroplasty, elbow, with distal humerus and proximal ulnar	0 085	21.07	450 5	4 0	4 0	82.5	50	17.5	15	150	30				1	2	1				3	1	
AAOS	**27130**	**Arthroplasty, acetabular and proximal femoral prosthetic**	**0.081**	**20.09**	**462**	**5.0**	**4.0**	**90**	**60**	**15**	**15**	**135**	**30**				**1**	**3**	**1**				**3**	**1**	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:20600 Global Period: 000 Specialty Society RVU: **0.94**

RUC RVU: **0.66**

CPT Descriptor· Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

For Upper Extremity:

A 50-year-old man with joint inflammation is treated by aspiration and injection of the metacarpophalangeal joint with a fine needle.

For Lower Extremity:

A 50-year-old man with joint inflammation is treated by aspiration and injection of the metatarsophalangeal joint with a fine needle

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

s conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review procedure with patient; discuss possible complications; obtain patient consent; prepare injection. The patient's involved hand or foot is placed on a sterile barrier and prepped. The physician gloves.

Description of Intra-Service Work: The joint is aspirated and after positive identification that the needle is inserted inside the joint, aspiration and/or injection is performed.

Description of Post-Service Work: The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection. Instruct patient and/or care giver on appropriate activities and home care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Dale Blasier, MD, American Academy of Orthopaedic Surgeons Lloyd Smith, DPM, American Podiatric Medical Association Frank Spinosa, DPM, American Podiatric Medical Association					
Specialty(s):	Orthopaedic Surgery, Podiatry					
CPT Code:	20600					
Sample Size:	125	**Resp n:** 30		**Response:** 24.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.70	0.88	**0.94**	1 20	1.50
Pre-Service Evaluation Time:				**0.0**		

CPT Code:

Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:			**0.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
20551	000	0.75

CPT Descriptor Injection(s); single tendon origin/insertion

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
20551	000	0.75

CPT Descriptor 1 Injection(s); single tendon origin/insertion

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
20526	000	0.94

CPT Descriptor Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	**CPT Code: 20600**	**Key Reference CPT Code: 20551**
Median Pre-Service Time	0.00	10.00
Median Intra-Service Time	0.00	5.00
Median Immediate Post-service Time	0.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**0.00**	**20.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.74	2.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.78	2.77
Urgency of medical decision making	2.41	2.31

Technical Skill/Physical Effort (Mean)

Technical skill required	3.04	3.04
Physical effort required	2.33	2.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.30	2.27
Outcome depends on the skill and judgment of physician	2 89	2 96
Estimated risk of malpractice suit with poor outcome	2.22	2.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.11	2.07
Intra-Service intensity/complexity	2.89	2.93
Post-Service intensity/complexity	2.22	2.15

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Orthopaedic Surgeons (AAOS) and the American Podiatric Medical Association (APMA) collected survey data for 20600 because CMS selected it for the current five-year review. The AAOS and APMA reviewed the survey data for 20600 and believed the time, intensity, and work RVWs were reasonable. The total time and overall intensity for 20600 was higher than the two reference codes (20551 and 20526) most often selected by respondents. As such, the AAOS and APMA believe the survey median RVW represents an appropriate value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CMS indicates 20600 billed with EM 58% of time

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 0%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) less complex (less work) no change 100%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 20600

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		11.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 10.0	Staff % of Physician time 91%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		11.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 10.0	Staff % of Physician time **Change:** **In Time** 91% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:20610 Global Period: 000 Specialty Society RVU: **1.8**

RUC RVU: **0.79**

CPT Descriptor: Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female with acute inflammation has the hip joint aspirated to collect fluid for culture.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 96%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Dale Blasier, MD, American Academy of Orthopaedic Surgeons					
Specialty(s):	Orthopaedic Surgery					
CPT Code:	20600					
Sample Size: 150	**Resp n:** 30	**Response:** 0.00 %				
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0 80	1 50	**1.80**	1 85	2 50	
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:			**0.00**			

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19), 99238 (36), 99215 (59), 99214 (38), 99213 (23); 99212 (15), 99211 (7).

CPT Code:

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
64470	000	1.85

CPT Descriptor Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
20551	000	0.75

CPT Descriptor 1 Injection(s); single tendon origin/insertion

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 80.0 %

TIME ESTIMATES (Median)	**CPT Code: 20610**	**Key Reference CPT Code: 64470**
Median Pre-Service Time	0.00	38.00
Median Intra-Service Time	0.00	20.00
Median Immediate Post-service Time	0.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**0.00**	**73.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	4 00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.00
Urgency of medical decision making	3.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.75
Physical effort required	4.00	3.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.75
Outcome depends on the skill and judgment of physician	4.00	3.75
Estimated risk of malpractice suit with poor outcome	4.00	3.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.75	3.00
Intra-Service intensity/complexity	4.00	3.75
Post-Service intensity/complexity	3 00	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Orthopaedic Surgeons (AAOS) collected survey data for 20610 because CMS selected it for the current five-year review. The AAOS reviewed the survey data for 20610 and believed the time, intensity, and work RVWs were reasonable. The total time and overall intensity for 20610 was comparable to the reference code (64470) most often selected by respondents. As such, the AAOS believes the survey median RVW represents an appropriate value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☒ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CMS indicates 20610 billed with EM 65% of time

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 0%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) less complex (less work) no change 100%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 20610

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		15.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 10.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		15.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 10.0	Staff % of Physician time **Change: In Time** 67% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:20680 Global Period: 090 Specialty Society RVU: **6.50**
RUC RVU: **5.86**

CPT Descriptor: Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 35-year-old ironworker who sustained a fracture of the femur treated by closed intramedullary nailing 18 months ago now undergoes removal or intramedullary nail (consider only the work involved in removing the intramedullary nail)

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service begins after the decision to remove the intramedullarly nail has been made and is from the day before the surgery until the time of the procedure. It includes reviewing the radiology images of the femur to assess the position of the implant in the bone, its relationship to bony landmarks and the features of the implant. The surgeon must observe the presence and location of locking screws. Appropriate equipment for removal of the implant must be available; this includes extraction equipment to lock into the top of the rod and appropriate screw drivers for screw removal. This might necessitate identifying and calling a local manufacturers representative to have this equipment available. On the day of the surgery, the surgeon must meet with the patient and patient's family to xplain operative risks, benefits and to obtain informed consent. The involved limb must be marked. A history and physical may need to be updated. The range of motion of the hip and knee and neurovascular status must be assessed. The exact location of all previous surgical scars must be identified. On radiographs, the presence of overlying, overgrown or entopic bone must be assessed. Pre operative work will also include scrubbing, supervising prepping and draping of the patient and again checking that all of the necessary equipment is available on the operating table. The surgeon needs to insure that C Arm fluoroscopy equipment is available during the procedure.

Description of Intra-Service Work: Based on pre operative planning, the first step is to identify the location of screws which lock the nail to the bone. Once they have been identified, incisions are made in the appropriate places and carried through superficial and deep layers down to the level of the bone. The screws then need to be removed with the appropriate screw driver. Usually, there are soft tissues that have in grown around the screw and these need to be removed with sharp instruments and bleeding controlled. Occasionally, the heads of the screws have become buried in bone or overgrown with new bone. When this happens, osteotomes and other bone cutting instruments are required to expose them. If they are extremely difficult to find, C Arm fluoroscopy must be brought in and the area of the bone where there is underlying screws identified and bony instruments are then directed in this direction. Occasionally, screws are stripped and will only back out with a positive capture mechanism or when another instrument is applied to the head of the screw to help extract it. Occasionally, there are broken screws. When this happens, it may be necessary for a counter incision to come down on the far side of the screw and the use of a high speed burr, fluoroscopy and other cutting instruments to expose the far end of the broken screw and remove it. As many as three or four screws may need to be removed through two or three separate incisions. These incisions are then closed in layers. The incision over the tip of the intramedullarly nail is then open and deepend in layers. Surface landmarks and palpation are used to identify the tip of the intramedullarly nail. Similar to the screws, this may be difficult and scar tissue may need to be removed with a series of sharp instruments. Occasionally, when overgrown with bone, osteotomies and other bone instruments re necessary. When the nail cannot be identified, C Arm fluoroscopy is used to direct cutting instruments in the correct direction through the bone. When the nail tip is exposed, soft tissue and bone elements are curetted from the entry hole into the nail. Typically, a screw in mechanism will fit onto the top of the nail. The nail is removed with back slapping onto an out rigger of this screw and instrument. The wound is then irrigated and closed in layers.

Description of Post-Service Work: The post service begins after skin closure in the operating room and includes application of a sterile dressing to the wounds. Post operative work may include reviewing x-rays that are made after hardware removal to make sure there has been no intra operative fracture. The surgeon will go over discharge nstructions with the patient and their family, including care of the incision, pain medication management, use of crutches and weight bearing instructions. Typically the patient will be seen for an office visit 2 weeks after the procedure for assessment of the wound, removal of sutures and assessment of joint range of motion. Generally, the patient's activities are progressed at this stage and one final post operative visit will be required during the 90 day global period prior to discharge.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Dale Blasier, MD, American Academy of Orthoapedic Surgeons Larry Marsh, MD, Orthopaedic Trauma Association David Volgas, MD, Orthopaedic Trauma Association					
Specialty(s):	Orthopaedic Surgery					
CPT Code:	20680					
Sample Size:	200	**Resp n:** 108		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		4.00	6.50	**6.50**	12.00	15.00
Pre-Service Evaluation Time:				**35.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		35.00	50.00	**50.00**	60.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**15.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**30.0**	99211x **0.0** 12x **2.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15); 99211 (7).

CPT Code:

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
27036	090	12.86

CPT Descriptor Capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles (ie, gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 49 **% of respondents:** 45.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 20680**	**Key Reference CPT Code: 27036**
Median Pre-Service Time	65.00	60.00
Median Intra-Service Time	50.00	120.00
Median Immediate Post-service Time	15.00	30.00
Median Critical Care Time	0.0	0 00
Median Other Hospital Visit Time	0.0	38.00
Median Discharge Day Management Time	18.0	36.00
Median Office Visit Time	30.0	92.00
Median Total Time	**178.00**	**376.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.94	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.25	2 67
Urgency of medical decision making	1.56	1.33

Technical Skill/Physical Effort (Mean)

Technical skill required	2.44	3.00
Physical effort required	2.69	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.19	3.00
Outcome depends on the skill and judgment of physician	2.56	3.00
Estimated risk of malpractice suit with poor outcome	2.44	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.13	2.67
Intra-Service intensity/complexity	2.69	3.33
Post-Service intensity/complexity	1.69	2.67

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SEE ATTACHED RATIONALE

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 33% No

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 20680

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		32.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 32.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 2.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		50.0	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 50.0	Staff % of Physician time **Change:** **In Time** 100% 18.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:24363 Global Period: 090 Specialty Society RVU: **21.00**
RUC RVU: **21.07**

CPT Descriptor: Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 58-year-old female undergoes total elbow replacement with humeral and ulnar replacement for rheumatoid arthritis.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service 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 scabbing; supervision of positioning, 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.

Description of Intra-Service Work: A posterior elbor incision is made. The ulnar nerve is identified for protection throughout the dissection. The triceps and extensor mechanism are released from a near insertion on the ulna and then displaced in a radial direction. The elbow joint is exposed and the synovium and capsule are released from the humerus with excision of the excess synovium after exposing the whole elbow joint. A burr and saw along with cutting guides are used to cut the proximal ulna and the distal humerus and a Coonrad-Morrey total elbow arthroplasty is performed using the technique as described. After trail components are inserted in a correct position, the final components are inserted using methylmethacrylate in order to complete the procedure. Extra bone is placed about the prosthesis as needed. The tourniquet is released, hemostatis is obtained, and the triceps tendon is re-approximated to the proximal ulna. The remainder of the extensor mechanism is approximated, subcutaneous tissue approximated, and the skin is closed.

Description of Post-Service Work: Post-service begins after skin closure in the operating room and included application of sterile dressing and a 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 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 physical 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 postoperative work for this procedure; including removal of staples; evaluation of periodic imaging reports; assessment of range of motion functioning; and antibiotic and pain medication adjustments.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005
Presenter(s):	Dale Blasier, MD, American Academy of Orthopaedic Surgeons David Kalainov, MD, American Society of Shoulder and Elbow Surgeons
Specialty(s):	Orthopaedic Surgery
CPT Code:	24363

CPT Code:

Sample Size: 400	**Resp n:** 32	**Response:** 8.00 %
Sample Type: Random		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	16.00	20.50	**21.70**	24.00	27.00
Pre-Service Evaluation Time:			**50.0**		
Pre-Service Positioning Time:			**17.5**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	100.00	120.00	**150.00**	165.00	240.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**68.0**	99231x **2.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**84.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
23472	090	21.07

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 38.7 %

TIME ESTIMATES (Median)	**CPT Code: 24363**	**Key Reference CPT Code: 23472**
Median Pre-Service Time	82.50	60 00
Median Intra-Service Time	150 00	165.00
Median Immediate Post-service Time	30 00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	68.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	84.0	84.00
Median Total Time	**450.50**	**443.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4 40	3.60
Urgency of medical decision making	3.40	2.70

Technical Skill/Physical Effort (Mean)

Technical skill required	3.20	4.50
Physical effort required	3.30	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.60	4.10
Outcome depends on the skill and judgment of physician	4.50	4.30
Estimated risk of malpractice suit with poor outcome	3 80	3.70

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.40	3.80
Intra-Service intensity/complexity	4.36	4.31
Post-Service intensity/complexity	3 80	3.85

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SEE ATTACHED RATIONALE

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 27% No

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 75%
B. Patients requiring this service are now:
   more complex (more work) 33% less complex (less work) no change 67%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 5.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:24430 Global Period: 090 Specialty Society RVU: **15.50**
RUC RVU: **14.00**

CPT Descriptor: Repair of nonunion or malunion, humerus; without graft (eg, compression technique)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43-year-old female has sustained a fracture of the humerus several months ago that has failed to heal properly. She is taken to the operating room for repair.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The pre service begins after the decision is made to operate and is from the day before the surgery until the time of the procedure. This includes reviewing radiology images of the nonunion to assess its location, alignment and degree of stability. These radiographic assessments are critical to planning the procedure. If old hardware is present, the type of hardware must be identified and the surgeon must assure that there is appropriate equipment to remove it. This might necessitate to call a local manufacturer's representative to have this equipment available. On the day of the surgery, the surgeon must meet with the patient and their family to explain the operative risks, benefits and obtain informed consent. The involved limb must be marked; history and physical may need to be updated. The range of motion of the elbow and shoulder and neurovascular status must be assessed. The exact location of all previous scars must be identified. The length and rotation of the limb must be assessed on physical examination. Pre operative work will also include scrubbing and supervising prepping and draping of the patient. All necessary equipment needs to be verified as available on the surgical table. The surgeon needs to ensure that C Arm fluoroscopy equipment is available during the procedure. Pre operative work up and pre operative laboratory values need to be reviewed.

Description of Intra-Service Work: The procedure begins with a skin incision. This will be in line with well known approaches to the humerus and may be anterior lateral or posterior. The muscles are split and in either approach the location and identification of critical neurovascular structures, particularly the radial nerve is necessary. If the radial nerve is in scar tissue from previous surgery this may need to be done in a very careful exacting fashion, dissecting it out over a considerable area of the operative field. An intraoperative nerve stimulator may be necessary. The nerve may need to be mobilized in the proximal and distal aspects of the incision to prevent excessive traction during the procedure. If previous hardware is in place, this will need to be removed either from the area of the fracture site or if it is an intramedullarly nail through separate proximal and maybe distal incisions. If the hardware is broken or failed, this can be time consuming and difficult as the hardware can be difficult to retrieve and imbedded in bone and scarred in the area of the radial nerve. After this is accomplished, the ends of the nonunion are mobilized. This involves removing fibrous tissue, dissecting around the ends of the bone and obtaining sufficient mobility to restore accurate alignment. The ends of the bone may need to be fashioned with power instruments to obtain optimal contact and to freshen bone ends to insure the best chance for healing. Intra operative fluoroscopic views may be necessary during this part of the procedure. Once the surgeon has obtained accurate contact to the bone, an implant is chosen. Typically, this will be a large broad plate of at least 8 holes but frequently as long as 12, 14 or 16 holes. This plate is applied to the bone. To obtain a good fit, the plate may need to be contoured using bending instruments or sections of hypertrophic bone may need to be removed. The surgeon must assure that the plate is accurately applied on both the proximal and distal segment. Intra operative x-ray may be necessary with clamps holding the plate and bone in position. Fixation is obtained by drilling and tapping and placing a screw either proximally or distally. The opposite section of the bone is then brought into optimal alignment and contact, secured to the distal aspect of the plate which is then drilled and tapped and then another screw is inserted. Typically, these screws are placed in an eccentric fashion to allow dynamic

compression. Sometimes the surgeon will chose to place an auxiliary compression apparatus in the proximal or distal aspect of the wound to compress the fracture site before fixation of the second side. Alignment must be seen to be accurate as well as having good bone contact. Additional screws are then inserted in the proximal and distal aspect of the plate using a similar technique until the surgeon is assured that adequate stability is obtained. This usually involves at east 4 screws both proximally and distally. If bone quality is poor, adjunctive measures are used to increase stability. Final intra operative x-rays in the AP and lateral planes are obtained. The status of the radial nerve is checked, the range of motion of the elbow and shoulder and the rotation of the arm are confirmed to be accurate. Closure is then in layers with one muscular layer, one subcutaneous layer and skin sutures, a drain may be left in the area of the operative field.

Description of Post-Service Work: Post service work begins after skin closure in the operating room and includes application of a sterile dressing to the wounds. Post operative work will include reviewing x-rays that are made after the procedure to assess the location of the implants, the contact of the nonunion site and the alignment of the limb. Post operative work also includes: Monitoring patient's stabilization in the recovery room; communication with the family and other health professionals (including written and oral reports/orders); all hospital visits and services performed by the surgeon including monitoring lab reports; care and removal of the drains and dressings; supervision of post operative physical therapy; ordering and reviewing post operative x-rays; ordering and maintaining antibiotic and pain medications. Discharge day management includes the surgeon's final examination of the patient, instructions for continuation of care including home health care and preparation of discharge records. Post operative office visits for this service requires frequent follow up during the 90 degree global period. The patient will need to be initially assessed at two weeks to check status of the wound, make sure there is healing and to remove sutures. Patient needs to be closely monitored for pain and physical therapy and ability to regain elbow and shoulder range of motion. In the second 6 weeks, radiographs are scrutinized to determine time to allow use of the arm and increase other activities. Pain medication needs to be adjusted during these post operative visits.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Dale Blasier, MD, American Academy of Orthoapedic Surgeons Larry Marsh, MD, Orthopaedic Trauma Association David Volgas, MD, Orthopaedic Trauma Association					
Specialty(s):	Orthopaedic Surgery					
CPT Code:	24430					
Sample Size:	200	**Resp n:** 40		**Response:** 20 00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		12.00	14.00	**14.00**	16.50	20.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**17.5**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		90.00	101.50	**101.50**	140.00	180.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**15.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**38.0**	99231x **2.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**84.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
27725	090	15.57

CPT Descriptor Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 33 **% of respondents:** 82.5 %

TIME ESTIMATES (Median)	CPT Code: 24430	Key Reference CPT Code: 27725
Median Pre-Service Time	62.50	60.00
Median Intra-Service Time	101.50	150.00
Median Immediate Post-service Time	15.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	38.0	57.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	84.0	122.00
Median Total Time	**337.00**	**455.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	3.20
Urgency of medical decision making	2.17	2.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.17	4.20
Physical effort required	3.67	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.67	3.80
Outcome depends on the skill and judgment of physician	3.67	3.83
Estimated risk of malpractice suit with poor outcome	3.83	3.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.50	3.67
Intra-Service intensity/complexity	3.83	3.80
Post-Service intensity/complexity	2 67	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SEE ATTACHED RATIONALE

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 28% No

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 24430

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:25447 Global Period: 090 **Recommended Work Relative Value** Specialty Society RVU: **10.35** RUC RVU:

CPT Descriptor: Arthroplasty, interposition, intercarpal or carpometacarpal joints

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old woman undergoes excision of the trapezium with interposition of local tissue between the scaphoid and base of the first metacarpal.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Consultation is completed with the referring physician and other healthcare professionals
- Reexamine patient to make sure that physical findings have not changed and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available

Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes

- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made over the base of the first metacarpal and trapezium. Careful dissection is carried out. Care is taken to protect the branches of the superficial branch of the radial nerve. The periosteum is elevated over the trapezium and the first carpometacarpal joint and scaphotrapeziotrapezoid joint are identified and opened. The trapezium is exposed via sub-periosteal resection, taking care to protect the radial artery. The trapezium is then excised piecemeal using osteotomes and a rongeur. Care is taken to protect the flexor carpi radialis. The base of the first metacarpal is cleared of any osteophytes. The flexor carpi radialis is identified in the wound. It is split longitudinally and the radial one half is harvested through two transverse incisions of the forearm. The radial one half of the flexor carpi radialis is then rolled onto itself and sewn together. This is sutured to the soft tissues in the depths of the void created by the trapeziectomy. The first ray is held in a somewhat adducted position and a Kirschner wire is passed through the first metacarpal into the second metacarpal. The wound is thoroughly irrigated. The capsule is repaired in a vest-over-pants fashion. The skin is approximated in layers

Description of Post-Service Work:
Post-service work: in hospital

- Application of dressing and splint.

- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies and labs are reviewed
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.
- Dictation of an operative report
- Procedure note is written in the patient chart

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Order/review radiographs.
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Nagle, MD; Dale Blasier, MD					
Specialty(s):	hand surgery; orthopaedic surgery					
CPT Code:	25447					
Sample Size:	150	**Resp n:** 54		**Response:** 36.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		5.50	10.00	**10.75**	11.00	18.00
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		40.00	60.00	**100.00**	100.00	150.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**20.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**91.0**	99211x **0.0** 12x **3.0** 13x **2.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
25320	090	10.75

CPT Descriptor Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 46 **% of respondents:** 85.1 %

TIME ESTIMATES (Median)	**CPT Code: 25447**	**Key Reference CPT Code: 25320**
Median Pre-Service Time	45.00	49.00
Median Intra-Service Time	100.00	120.00
Median Immediate Post-service Time	20 00	100.00
Median Critical Care Time	0 0	0.00
Median Other Hospital Visit Time	0 0	0.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	91.0	175.00
Median Total Time	**274.00**	**444.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.97	3.57
Urgency of medical decision making	3.33	2.86
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.37	4.08
Physical effort required	3.26	3.35
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.30	3.54
Outcome depends on the skill and judgment of physician	4.00	4.05
Estimated risk of malpractice suit with poor outcome	3.23	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.63	3.49
Intra-Service intensity/complexity	3.77	3.98
Post-Service intensity/complexity	3.14	3.38

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
COMPELLING EVIDENCE RATIONALE:

CMS nominated code 25447 for review during this 5YR. The current time and visit data are Harvard-based.

Discussion: CPT 25320 Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability was cited most often as a

reference for 25447 Arthroplasty, interposition, intercarpal or carpometacarpal joints. We believe that the recorded intra-operative time for 25320 is longer than the surveyed median intra-time for 25447 because the service description for 25320 included the application of a dressing and a splint within the intraoperative component of service (see RUC database service description.) This code was surveyed in the early years of the RUC.

The Harvard pre-service time is low compared with other hand surgery codes. No time was allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder. Pre-service work and immediate post-service work for both of these outpatient procedures will be similar. It is also our estimation that the visit levels would be similar for both codes.

That being said, our consensus panel agree with the 54 survey respondents indication that the total work for both of these procedures is very similar. The survey median RVW 10.75 is the RVW for 25320. This results in an IWPUT of 0.062. The current RVW for 25447 is 10.35 with and IWPUT of 0 058 This is very similar to the survey median. Therefore, we are recommending the current RVW of 10.35 for 25447 be maintained, but ask that the time and visit details from our full RUC survey replace the Harvard data in the RUC database. .

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 13% No 87%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 14% I do not agree 86%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) -0% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:26055 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **3.99**
RUC RVU: **2.69**

CPT Descriptor: Tendon sheath incision (eg, for trigger finger)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old woman with a three month history of "catching" of the right ring finger undergoes a release of the A-1 pulley of the right ring finger.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Consultation is completed with the referring physician and other healthcare professionals
- Reexamine patient to make sure that physical findings have not changed and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made over the proximal edge of the right ring finger A-1 pulley in the distal palmar flexion crease. Careful dissection is carried out, taking care to protect the underlying common digital arteries and digital nerves. The edge of the A-1 pulley is identified. Tenotomy scissors are used to incise the A-1 pulley along its length. The dissection is then carried out more proximally and the flexor tendon sheath is released proximal to the incision, , taking care to not injure the neurovascular structures. The patient is asked to make a fist and if there is any further triggering, further release of the pulley system is carried out, taking care to maintain the integrity of the A-2 pulley to avoid postoperative bow stringing. Once the tendon sheath has been adequately released, the wound is thoroughly irrigated and then sutured.

Description of Post-Service Work:
Post-service work: in hospital
- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.

- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies and labs are reviewed
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.
- Dictation of an operative report
- Procedure note is written in the patient chart

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Nagle, MD; Dale Blasier, MD					
Specialty(s):	hand surgery; orthopaedic surgery					
CPT Code:	26055					
Sample Size:	150	**Resp n:** 31		**Response:** 20.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		3.00	3.37	**3.99**	4.50	5.00
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		10.00	15.00	**20.00**	24.00	30 00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**20.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**53.0**	99211x **0.0** 12x **2.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
25001	090	3.37

CPT Descriptor Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 90.3 %

TIME ESTIMATES (Median)

	CPT Code: 26055	**Key Reference CPT Code: 25001**
Median Pre-Service Time	40.00	30.00
Median Intra-Service Time	20.00	30.00
Median Immediate Post-service Time	20.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	18.00
Median Office Visit Time	53 0	53.00
Median Total Time	**151.00**	**151.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.23	2.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.09	2.18
Urgency of medical decision making	1.82	1.55

Technical Skill/Physical Effort (Mean)

Technical skill required	2 14	2.27
Physical effort required	1 95	1.95

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.62	2.27
Outcome depends on the skill and judgment of physician	2.23	2.55
Estimated risk of malpractice suit with poor outcome	1.95	2.32

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2 19	2.24
Intra-Service intensity/complexity	2.10	2.45
Post-Service intensity/complexity	1.90	2.38

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
CMS nominated code 26055 for review during this 5YR. The current time and visit data are Harvard-based.

Discussion: CPT 25001 Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis) was cited most often as a reference for 26055 Tendon sheath incision (eg, for trigger finger) Although 25001 involves a longer incision than 26055 and would require more time for exposure and closure, the intensity of 26055 is greater because of the increased danger of flexor tendon as well as digital artery and nerve injury. The Harvard pre-service time is low compared with

other hand surgery codes. No time was allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder. Pre- and post-service work would be identical, including the number and level of office visits.

Our consensus panel analyzed the current RVW (2.69) with the current survey data. The result was a negative IWPUT (-0.037). The survey median RVW of 3.99 results in an IWPUT of 0.028, which is still less than an E/M service. We are recommending the median RVW of 3.99 for 26055. This value is very conservative for this procedure. We also ask that the time and visit details from our full RUC survey replace the Harvard data in the RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 27% No 73%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 13% I do not agree 88%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) 0% no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26055

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.00	
Clinical Staff #1	Staff Type: blend	Intra Assist Physician Time: 25.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type: blenc	Intra Assist Physician Time: 25.0	Staff % of Physician time 100%
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		20.0		
Clinical Staff #1	Staff Type: blend	Intra Assist Physician Time: 20.0	Staff % of Physician time 100%	**Change: In Time** -5.0
Clinical Staff #2	Staff Type: blend	Intra Assist Physician Time: 20.0	Staff % of Physician time 100%	**Change: In Time** -5.0
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:** 0.5		
Number and Level of Office Visits:		**99211:**		
		99212: 2.0		
		99213: 1.0		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:26160 Global Period: 090 Specialty Society RVU: **4.05**

RUC RVU: **3.15**

CPT Descriptor: Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old women undergoes excision of a ganglion cyst from the A-2 pulley of the right long finger.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Consultation is completed with the referring physician and other healthcare professionals
- Reexamine patient to make sure that physical findings have not changed and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A Bruner incision is made over the area of the cyst in the region of the proximal right long finger. Careful dissection is carried out to the cyst. Care is taken to protect the adjacent radial and ulnar digital arteries and nerves. The cyst is identified. The cyst is carefully elevated off of the A-2 pulley until its stalk is identified. The A-2 pulley is then carefully incised, taking care not to penetrate the underlying flexor tendon. The A-2 pulley is incised longitudinally and then transversally removing a window of the A-2 pulley along the stalk and the ganglion. Care is taken not to disrupt the overall integrity of the A-2 pulley so as to avoid any postoperative bowstringing. A specimen is sent to pathology. The wound is thoroughly irrigated, repaired, and then sutured

Description of Post-Service Work:

Post-service work: in hospital

- Application of dressing and splint.
  Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies and labs are reviewed
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.
- Dictation of an operative report
- Procedure note is written in the patient chart

Post-service work: in office

- Examine and talk with patient
- Review pathology report
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Nagle, MD; Dale Blasier, MD					
Specialty(s):	hand surgery; orthopaedic surgery					
CPT Code:	26160					
Sample Size:	150	**Resp n:** 33		**Response:** 22.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		3.00	3.50	**4.05**	4.30	5 50
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		10.00	15.00	**20.00**	30.00	45.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**20.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**53.0**	99211x **0.0** 12x **2.0** 13x **1.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
25001	090	3.37

CPT Descriptor Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 74.1 %

TIME ESTIMATES (Median)	**CPT Code: 26160**	**Key Reference CPT Code: 25001**
Median Pre-Service Time	40.00	30.00
Median Intra-Service Time	20.00	30.00
Median Immediate Post-service Time	20.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	18.00
Median Office Visit Time	53.0	53.00
Median Total Time	**151.00**	**151.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.17	2.47
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.22	1.94
Urgency of medical decision making	1.78	1.65

Technical Skill/Physical Effort (Mean)

Technical skill required	2.29	2.53
Physical effort required	1.81	2.06

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.62	2.29
Outcome depends on the skill and judgment of physician	2.52	2.94
Estimated risk of malpractice suit with poor outcome	2 10	2.65

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.00	2.14
Intra-Service intensity/complexity	2.25	2.90
Post-Service intensity/complexity	1.75	2.52

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
CMS nominated code 26160 for review during this 5YR. The current time and visit data are Harvard-based.

Discussion: CPT 25001 Incision, flexor tendon sheath, wrist (eg, flexor carpi radialis) was cited most often as a reference for 26160 Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger. Although 25001 involves a longer incision than 26160 and would require more time for exposure and closure, the intensity of 26160 is greater because of the increased danger of flexor tendon as well as digital artery and nerve injury

No time was allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder. Pre-service and post-service facility work will be identical, including the number and level of office visits.

Our consensus panel analyzed the current RVW (3.15) with the current survey data. The result was a negative IWPUT (-0.014). The survey median RVW of 4.05 results in an IWPUT of 0.031, which is the same as an E/M service. We are recommending the median RVW of 4.05 for 26160. This value is conservative for this procedure. We also ask that the time and visit details from our full RUC survey replace the Harvard data in the RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 16% No 84%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 80% less complex (less work) 0% no change 20%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 2616

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		33.00	
Clinical Staff #1	Staff Type: blend	Intra Assist Physician Time: 33.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type: blend	Intra Assist Physician Time: 33.0	Staff % of Physician time 100%
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 3.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		20.0		
Clinical Staff #1	Staff Type: blend	Intra Assist Physician Time: 20.0	Staff % of Physician time 100%	**Change: In Time** -13.0
Clinical Staff #2	Staff Type: blend	Intra Assist Physician Time: 20.0	Staff % of Physician time 100%	**Change: In Time** -13.0
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:** 0.5		
Number and Level of Office Visits:		**99211:**		
		99212: 2.0		
		99213: 1.0		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:26600 | Global Period: 090 | **Recommended Work Relative Value**
Specialty Society RVU: **2.40**
RUC RVU: **2.40**

CPT Descriptor: Closed treatment of metacarpal fracture, single; without manipulation, each bone

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old man presents with an undisplaced fracture of the fourth metacarpal shaft after being stuck in the hand by a fast pitch. The fracture requires no manipulation and is treated with an ulnar gutter splint.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Explain procedure to patient/family
- Review risks and complications associated with fracture splinting
- Review expected outcome of treatment
- Review X-rays
- Verify that all required instruments and supplies are available
- Assist with extremity positioning
- Verify fracture site

Description of Intra-Service Work: The length of the splint is measured. The appropriate thickness and length of casting material is prepared. The appropriate length and thickness of cast padding is prepared. The splint material is submerged in water. The excess water is wrung from the splint. The casting material is placed on the measured cast padding. The cast padding and splint material are then transferred to the ulnar border of the fingers, hand wrist, and forearm. The splint material is then covered with a layer of cast padding. An elastic bandage is carefully (not too tightly) applied to the exterior of the splint . The casting material is molded to maintain the wrist in extension and the fingers in the intrinsic plus position. The casting material is trimmed so as to permit unobstructed finger range of motion

Description of Post-Service Work:
Post-service work prior to discharge from office:
- Communication with health care professionals including written and oral reports and orders.
- Post-service imaging studies are ordered and reviewed
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions orders.
- Write brief procedure note in patient chart
- Dictate procedure for medical record, copy PCP and insurance

Post-service work- follow up office visits
- Examine and talk with patient
- Answer patient/family questions
- Removal of splint
- Assess of circulation, sensation and motor function of the operated extremity
  Order occupational therapy
- Supervision of rehabilitation
- Order/review radiographs.
- Discuss progress with PCP (verbal and written)

- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Nagle, MD; Dale Blasier, MD					
Specialty(s):	hand surgery; orthopaedic surgery					
CPT Code:	26600					
Sample Size:	150	**Resp n:** 39		**Response:** 26.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.50	2.00	**2.40**	3.00	4.50
Pre-Service Evaluation Time:				**7.0**		
Pre-Service Positioning Time:				**2.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	5.00	**15.00**	15.00	30.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**60.0**	99211x **0.0** 12x **4.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
26720	090	1.66

CPT Descriptor Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 79.4 %

TIME ESTIMATES (Median)	CPT Code: 26600	Key Reference CPT Code: 26720
Median Pre-Service Time	9.00	9.00
Median Intra-Service Time	15.00	18.00
Median Immediate Post-service Time	5.00	4.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	60.0	30.00
Median Total Time	**89.00**	**61.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.81	1 75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.90	1.85
Urgency of medical decision making	1.86	2.05

Technical Skill/Physical Effort (Mean)

Technical skill required	1.94	1.85
Physical effort required	2.03	1 90

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2 32	2.30
Outcome depends on the skill and judgment of physician	2.19	2.25
Estimated risk of malpractice suit with poor outcome	1.94	2.35

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.07	2.10
Intra-Service intensity/complexity	2 00	2 42
Post-Service intensity/complexity	2.10	2.39

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
CMS nominated code 26600 for review during this 5YR. The current time and visit data are Harvard-based.

Discussion: Even though CPT 26720 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each was cited most often as a reference for 26600 Closed treatment of metacarpal fracture, single; without manipulation, each bone we do not believe that 26720 includes accurate data in the Harvard

data. Specifically, the number of post-op visits is understated. Each level 2 office visit (RVW of 0.45) represents 25% of the total RVW for this 26720.

That being said, our consensus panel analyzed the current RVW (1.96) with the current survey data. The result was a negative IWPUT (-0.005). The survey median RVW of 2.40 results in an IWPUT of 0.024, which is less than an E/M service and similar to the IWPUT that Harvard assigned to the evaluation, positioning, and immediate post-time components. Because the intra-service work is very similar to the immediate post-service work of applying dressings, we believe the survey median represents a reasonable value for this code. We are recommending the median RVW of 2.40 for 26600. We also ask that the time and visit details from our full RUC survey replace the Harvard data in the RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 10% No 90%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 80% less complex (less work) 0% no change 20%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 26600

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		19.00	
Clinical Staff #1	Staff Type: blend	Intra Assist Physician Time: 19.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 2.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		15.0	
Clinical Staff #1	Staff Type: blend	Intra Assist Physician Time: 15.0	Staff % of Physician time 100% **Change: In Time** -4.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:26951 Global Period: 090 Specialty Society RVU: **6.00**
RUC RVU: **5.25**

CPT Descriptor: Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old carpenter undergoes completion of an amputation of the left ring finer at the level of the proximal interphalangeal joint. Traction digital nerve neurectomies are completed and direct closure performed

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Consultation is completed with the referring physician and other healthcare professionals
- Reexamine patient to make sure that physical findings have not changed and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A fish-mouth incision is made over the healthy portion of the ring finger. Careful dissection is carried out. The radial and ulnar digital arteries and nerves are identified. The digital arteries are isolated and cauterized. The radial and ulnar digital nerves are identified and dissected proximally into the proximal ring finger. Under direct vision, traction neurectomies of the radial and ulnar digital nerves are performed. The flexor digitorum profundus and flexor digitorum superficialis are identified, transected and allowed to retract into the hand. The extensor mechanism is also identified dorsally and transected. The interphalangeal joint is identified and the collateral ligaments, volar plate, and capsule are all transected. The distal aspect of the phalanx is rongeured to decrease its bulk. The wound is thoroughly irrigated. The tourniquet is released and the vascular supply of the flaps is noted. Bipolar electrocautery is used for hemostasis. The skin is then sutured.

Description of Post-Service Work:
Post-service work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies and labs are reviewed
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.
- Dictation of an operative report
- Procedure note is written in the patient chart

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess circulation, sensation and motor function of the operated extremity
- Redress wound
- Order physical / occupational therapy
- Supervision of rehabilitation
- Order/review radiographs.
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Nagle, MD; Dale Blasier, MD					
Specialty(s):	hand surgery; orthopaedic surgery					
CPT Code:	26951					
Sample Size:	150	**Resp n:** 31		**Response:** 20.6 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		4.56	5 25	**5.25**	6 50	8.00
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		20.00	30.00	**30.00**	45.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**20.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		

Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**91.0**	99211x **0.0** 12x **3.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
.6185	090	5.24

CPT Descriptor Sesamoidectomy, thumb or finger (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 40.0 %

TIME ESTIMATES (Median)

	CPT Code: 26951	Key Reference CPT Code: 26185
Median Pre-Service Time	40.00	40.00
Median Intra-Service Time	45.00	45.00
Median Immediate Post-service Time	20.00	25.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	91 0	92.00
Median Total Time	**214.00**	**202.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.45	2.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	2.09
Urgency of medical decision making	2.09	1 91

Technical Skill/Physical Effort (Mean)

Technical skill required	2.09	2.73
Physical effort required	1.91	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.18	2.45
Outcome depends on the skill and judgment of physician	3.09	2.82
Estimated risk of malpractice suit with poor outcome	2.18	2.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.64	3.09
Intra-Service intensity/complexity	2.82	3.18
Post-Service intensity/complexity	2.45	2.64

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
CMS nominated code 26951 for review during this 5YR. The current time and visit data are Harvard-based.

Discussion: CPT 26185 Sesamoidectomy, thumb or finger (separate procedure) was cited most often as a reference for 26951 Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure. Intra-operative work (time and intensity) is similar for both procedures, which involve dissection of neurovascular structures. The Harvard pre-service time is low compared with other hand surgery codes. No time was

allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder. Pre-service and post-service facility work will be identical. 26951 includes one more office visit than 26185. The extra visit stems from the fact that digits which undergo amputation have often been traumatized and have compromised soft tissues that require closer monitoring than would a non-traumatized digit undergoing a sesamoidectomy. Additionally, amputated digits frequently develop post- amputation hypersensitivity that requires prolonged monitoring of the desensitization process.

Our consensus panel analyzed the current RVW (4.58) with the current survey data. The result was a negligible IWPUT (0.002). The survey median RVW of 6.00 results in an IWPUT of 0.033, which is slightly greater than an E/M service. We are recommending the median RVW of 6.00 for 26951. We also ask that the time and visit details from our full RUC survey replace the Harvard data in the RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 17% No 83%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 80% less complex (less work) 0% no change 20%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 40% no change 60%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212: 3.5	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 3 0	
		99213: 2.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27130 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **20.09**
RUC RVU: **20.09**

CPT Descriptor: Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

CLINCIAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old obese female (BMI > 30) with osteoarthritis of the lumbar spine and chronic low back pain presents with severe left hip pain affecting activities of daily living. She is hypertensive and a non-insulin dependent diabetic. At operation, she undergoes a conventional total left hip arthroplasty (THA).

Percentage of Survey Respondents who found the Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Description of Pre-Service Work: 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 preoperative laboratory test; 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. Templating of the case which includes leg length measurement, assessment of the center of rotation of the hip, the proper height for the femoral neck cut as well as the proper sizing of the components. Preoperative work also includes scrubbing; arranging for intraoperative cell saver; positioning the patient, assessing leg length before the patient is placed in the lateral position; 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.

Description of Intra-Service Work: After incising the skin and the fascia the glutei were taken off the femur one at a time. Once this was completed, leg length assessment is done by placing markers in the pelvis and in the femur as well as checking through the drapes. After assessing leg length and doing a capsulectomy, the femoral head is then dislocated and femoral neck osteotomy is performed at the proper height. This is then followed by finding the femoral canal and then doing sequential raspings with the broaches until the correct rotational and axial stability is achieved. The calcar planer is then utilized to plane down the neck.

The appropriate dissection and releases were then performed to expose the socket. The appropriate retractors are then placed anteriorly as well as posteriorly, all excess capsule and redundant labrum is then removed utilizing the knife. All osteophytes are then carefully removed utilizing each of the osteotomes starting with a half inch all the way up to the one inch osteotomes. After removal of the osteophytes, the base of the acetabulum is then found by utilizing a small reamer. Once the reamer is carefully placed all the way down to the medial wall of the acetabulum, sequential reamers in 1 mm increments are utilized all the way up to correct size. This is determined based on the axial and offcenter loading of the reamers. Once this is completed, trial implants are seated and stability as well as leg length measurement are them done. Once the proper sizing and stability issues are determined, the socket is seated. The drill is then utilized and placed over the holes for the socket to insert screws. Usually 2 are depth gaged and then inserted. The central hole sealer is then placed in situ and the liner is then placed and tapped after cleaning all soft tissue.

Once this was completed, trial reduction with the rasp is done again to check stability and range of motion for impingement or dislocation. Redundant capsule is then removed from the posterior aspect. The implant is then opened up and checked and then its placed and tapped in situ. Once this is completed, copious irrigation is done. Leg length is then assessed again with trial necks. The real head/neck is then placed and tapped in situ. The hip is then reduced. An x-ray is taken to verify the position of the components. Sponge and needle counts are then done and then a deep drain is placed. The closure is then performed in multilayers being careful to reattach the muscles to the proper structures.

Description of Post-Service Work: Post-service begins after skin closure in the operating room and includes application of sterile dressing and abduction splint. Post-operative 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, anticoagulant and pain medication management. Arrangements are made with the case manager and the patient's family for discharge to an inpatient rehabilitation facility or a skilled nursing facility or home. 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; review of anticoagulation laboratory values and appropriate medication adjustment, 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.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005
Presenter(s):	Dale Blasier, MD, American Academy of Orthopaedic Surgeons Carlos Lavernia, MD, American Association of Hip and Knee Surgeons Brian Parsley, MD, American Association of Hip and Knee Surgeons Frank Voss, MD, American Association of Hip and Knee Surgeons
Specialty(s):	Orthopaedic Surgery
CPT Code:	27130

Sample Size: 500 | **Resp n:** 42 | **Response:** 8%

Sample Type: Random

	Low	25th pctl	Median	75th pctl	High
RVW:	19.00	20.00	**20.50**	21.95	24.59
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	70.00	90.00	**135**	120.00	180.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**87.0**	99231x **3.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**84.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3472	090	21.07

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	CPT Code: 27130	Key Reference CPT Code: 23472
Median Pre-Service Time	90	60.00
Median Intra-Service Time	135	165.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	87.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	84.0	84.00
Median Total Time	**462**	**443.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.21	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	2.93
Urgency of medical decision making	2.43	2.29

Technical Skill/Physical Effort (Mean)

Technical skill required	3.86	3.86
Physical effort required	3.79	3.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.79	3.50
Outcome depends on the skill and judgment of physician	3.93	2.93
Estimated risk of malpractice suit with poor outcome	4.14	2.29

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.50	3.21
Intra-Service intensity/complexity	3.71	3.50
Post-Service intensity/complexity	3.14	2.93

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AAOS and AAHKS convened an expert panel to develop a RVW recommendation for 27130 using survey data, National Surgical Quality Improvement Program (NSQIP) data, and CMS DRG data. The expert panel's rationale is discussed in detail below.

Pre-Service Time

The expert panel reviewed the pre-service time data from the RUC survey and agreed the times were appropriate. The expert panel noted that 60 minutes of evaluation time was higher as compared to other surgical procedures, but it was still within the range of evaluation time for 90-day global procedures. The expert panel believes the increased evaluation time for this procedure can be accounted for by the templating that is typically performed as part of the pre-service work. The 15 minutes of positioning time and 15 minutes of scrub, dress, wait time are typical for 90-day global procedures – especially with respect to orthopaedic procedures.

The expert panel recommends 95 minutes of total pre-service time for 27130, and specifically recommends 60 minutes evaluation, 15 minutes positioning, and 15 minutes scrub, dress, and wait time.

Intra-Service Time

The expert panel reviewed the intra-service time data from the RUC survey and believed the median time of 110 minutes did not fully capture all of the intra-service time required for this procedure. As such, the expert panel looked to other objective sources of data in order to develop appropriate intra-service time recommendations.

The National Surgical Quality Improvement Project (NSQIP) is a national, validated, outcomes-based, risk adjusted program that measures aspects of surgical care. NSQIP intra-operative data indicate a median intra-operative time of 135 minutes for 27130, based on 5,950 patient records.

The expert panel also considered the CMS DRG database, which includes actual operating room time for 27130, compiled from automated hospital tracking software. This data was used by CMS in early 2005 to update the DRG for total joint arthroplasty under Medicare's Inpatient Prospective Payment System. The mean total operating room time for 3,048 total hip arthroplasty cases (27130) was 198.7 minutes. To estimate the skin-to-skin time, we subtracted the positioning time (20 minutes), scrub/dress/wait time (15 minutes), and a portion of the immediate post-time through discharge from recovery (20 minutes) from the total OR time (198.7 minutes) to arrive at an estimate of 143.7 minutes (198.7 – 55 = 143.7).

The expert panel recommends 135 minutes of intra-operative time for 27130 and bases this recommendation on its review of the data from these two large databases. The expert panel bases its recommendation on 8,998 actual cases from independent, national, hospital databases. The expert panel believes the voluminous intra-service data from the NSQIP and DRG database is considerably more reliable than the estimates of intra-service time collected from the RUC survey data.

Post-Service Time

The expert panel reviewed the immediate post-service time data from the RUC survey and agreed 30 minutes of immediate post-service time was appropriate. The expert panel noted the immediate post-service time for the reference code 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*, is also 30 minutes. 30 minutes falls within the range of immediate post-service time for 90-day global procedures – especially with respect to orthopaedic procedures.

The expert panel recommends 30 minutes post-service time for 27130.

Hospital Visits

The expert panel reviewed the post-operative hospital visit data from the RUC survey and believed survey respondents accurately identified the number and intensity of hospital visits required for this procedure. The expert panel validated the number of hospital visits indicated by survey respondents by comparing the survey results with two large databases. The expert panel noted that the survey results were consistent with the databases. The NSQIP data for 27130 indicates the total hospital length of stay (LOS) is 5 days. The NSQIP LOS data is based on 5,917 total hip arthroplasty cases. The CMS DRG database shows the mean hospital length of stay as 5.1 days. This data is based on 3,048 total hip arthroplasty cases.

The expert panel recommends 5 hospital visits (99231x3, 992232x1, 99238x1) for 27130. The expert panel bases its 5-day hospital length of stay recommendation on both RUC survey and actual data from 8,965 cases from independent, national hospital databases which confirmed the survey results. The expert panel agrees with survey respondents in the fact that one higher level hospital visit (99232) is appropriate because the initial hospital visit following surgery requires additional time and effort as compared to subsequent hospital visits. For example, the physician must address pain management, initiate DVT prophylaxis, and develop a PT regimen during this visit.

Office Visits

The expert panel reviewed the post-operative office visit data from the RUC survey and agreed the number and intensity of office visits were appropriate. The expert panel noted this office visit pattern is identical to the reference code selected by survey respondents, 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*, which is a RUC-surveyed code. Both procedures share similar patterns of post-operative care with respect to the number and intensity of office visits.

The expert panel recommends 4 office visits (99213x3, 99212x1) for 27130.

RVW

The expert panel noted its pre-, intra-, and post-operative time recommendations reflect higher times than the existing Harvard data. The expert panel also noted the overall intensity measures were similar for 27130 and the most commonly selected reference code, 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*. The post-operative office visits for 27130 and the reference code (23472) were identical.

The expert panel noted there was a difference in the number of hospital visits from the Harvard data as compared to the survey data; however, they believed it was inappropriate to make this comparison for several reasons. First, when the Harvard hospital time (91 minutes) is compared with the Harvard number of hospital visits (99231x8, 99238x1), it suggests either a lower intensity visit was used for the Harvard study than is currently used by the RUC, or the number of visits were extrapolated from the total time. Second, it is unclear as to whether more than one hospital visit per day was reported under the Harvard study. If this was the case, it is inconsistent with current RUC and CPT standards which allow a physician to report only one visit per day. Because of these methodological differences, the expert panel believes the Harvard hospital visit data cannot be compared with RUC survey data. The expert panel believes the current RUC survey and NSQIP data accurately reflect the number and intensity of post-operative hospital visits and also believed there has been no decrease in the amount work required for post-operative hospital care.

The expert panel noted the survey median RVW of 20.50 was a slight increase from the current RVW of 20.09. The median survey RVW suggests that survey respondents believe the overall work involved for this procedure has not significantly changed. After consideration of the time, visit, and intensity factors, the **expert panel agrees and recommends maintaining the current RVW of 20.09 for 27130.**

IWPUT

The IWPUT calculations using the time and visit recommendations of the expert panel and the current RVW for 27130 is shown below.

IWPUT for 27130			**RVW**
		RVW:	**20.09**
	Data	**RUC Std.**	**RVW**
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	75	0.0224	1.34
Pre-service scrub, dress, wait	15	0.0081	0 16
Pre-service total			**1.51**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0 0224	0.67
Subsequent visits		**E/M RVW**	**(=n x RVW)**
ICU 99291		4 00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233		1.51	0.00
99232	1	1.06	1.06
99231	3	0.64	1.92
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1.73	0.00
99214		1.08	0.00
99213	3	0.65	1.95
99212	1	0.43	0.00
99211		0 17	0 00
Post-service total			**7.35**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	135	**0.081**	11.16

The AAOS and AAHKS believe it is appropriate to maintain the current RVW of 20.09 for 27130. Additionally, the AAOS and AAHKS recommend the time and visit data presented replace the Harvard data in the CMS and RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 51% No 49%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27130

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27236 | Global Period: 090 | **Recommended Work Relative Value**
Specialty Society RVU: **15.58**
RUC RVU: **15.58**

CPT Descriptor: Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement)

CLINCIAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old obese female (BMI > 30) with mild dementia, severe osteoporosis, heart disease, and non-insulin dependent diabetes falls and sustains a displaced femoral neck fracture. At operation, she undergoes a cemented, bipolar prosthetic replacement.

Percentage of Survey Respondents who found the Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Description of Pre-Service Work: Obtaining and reviewing previous medical records, review of chest x-ray, EKG, and pre-operative laboratory work-up. Consultation with the patient's internist, the anesthesiologist, and/or other health professionals (e.g., cardiologist) regarding any pre-operative testing that is required in order to clear the patient for surgery. Communicating with the patient and the patient's family to explain the operative risks and benefits and to obtain informed consent, emphasizing that there is a 50% mortality at 1 year following hip fracture in octogenarians. Review of radiographs, which are used for sizing and ordering of implants. Preoperative work also includes scrubbing; 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 uite.

Description of Intra-Service Work: The skin incision is made down through subcutaneous tissue, followed by a fascial incision and splitting of the gluteus maximus. Dissection is made to identify the greater trochanter, vastus lateralis. The sciatic nerve is at risk. Short external rotators and capsule from posterior intertrochanteric insertions areincised; rotators are tagged and pulled over the sciatic nerve. The leg length is measured. The posterior capsule is then incised and tagged for future repair. The surgeon then attempts to displace the proximal femur anteriorly, thus exposing the femoral head, which remains in the acetabulum. A cut is made along the femoral neck based on pre-operative templating. The femoral head is then removed with a corkscrew. The acetabular socket is exposed and inspected for any signs of damage to the articular cartilage. If there is none, the acetabulum is sized using a trial head. The proximal femur is then delivered up into the wound with flexion and internal rotation of the hip. A box-cutting chisel and awl are used to create a starting hole for the femoral broaches. Beginning with the smallest size broach, the femoral canal is broached to the appropriate size. A trial reduction is performed by attaching a trial femoral head and neck to the broach, and reducing the hip under direct vision. The hip is taken through a range of motion to assess the stability of the hip in flexion/internal rotation and extension/external rotation. Leg lengths are assessed. If the surgeon is not comfortable with the leg length and/or stability, additional head/neck length combinations are used to achieve stability. An intra-operative x-ray is obtained to determine the positioning of the implants and the leg lengths. The trial hip is then dislocated using a bone hook, and the trial implants are removed. A femoral canal sound is used to determine the size of the femoral canal, and the appropriate sized cement restrictor and distal centralizer are selected. The cement restrictor is impacted into the femoral canal. The femoral canal is then prepared for cementing using pulsatile lavage, a brush, and epinephrine-soaked gauze sponges. Methylmethacrylate cement is then vaccum-mixed. While the cement is curing, it is transferred to a cement gun. When the cement becomes doughy, it is inserted retrograde into the femoral canal. Once the canal is full of cement, the cement column is pressurized using a proximal cement pressurizing. The ppropriate sized femoral implant is then inserted into the femoral canal in the appropriate amount of anteversion. Excess cement is removed, and pressure is held on the implant until the cement completely hardens (12-15 minutes). Once the cement has hardened, excess cement is again removed with a curved osteotome. A trial reduction is again performed with various head/neck combinations until the surgeon is satisfied with the stability of the hip and leg

lengths. The trial head/neck are then removed and replaced with the final implant. The hip is reduced under direct vision, and again taken through a range of motion to determine the final stability and leg length. The posterior capsule and the short external rotators are reattached though 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.

Description of Post-Service Work: Post-service begins after skin closure in the operating room and includes application of sterile dressing and abduction splint. Post-operative 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, anticoagulant and pain medication management. Arrangements are made with the case manager and the patient's family for discharge to an inpatient rehabilitation facility or a skilled nursing facility. 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; review of anticoagulation laboratory values and appropriate medication adjustment, 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.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005
Presenter(s).	Dale Blasier, MD, American Academy of Orthopaedic Surgeons Carlos Lavernia, MD, American Association of Hip and Knee Surgeons Brian Parsley, MD, American Association of Hip and Knee Surgeons Frank Voss, MD, American Association of Hip and Knee Surgeons
Specialty(s):	Orthopaedic Surgery
CPT Code:	27236

Sample Size: 500	**Resp n:** 42	**Response:** 8%
Sample Type: Random		

	Low	25th pctl	Median	75th pctl	High
RVW:	15.00	17.00	**19.17**	21.13	45.00
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15**		
Intra-Service Time:	60.00	98.00	**90**	130.00	210.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**79.0**	99231x **1.0** 99232x **2.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**84.0**	99211x **0.0** 12x **1.0** 13x **3.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
23472	090	21.07

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	**CPT Code: 27236**	**Key Reference CPT Code: 23472**
Median Pre-Service Time	90	60.00
Median Intra-Service Time	90	165.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	79.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	84.0	84.00
Median Total Time	**409**	**443.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.35	3.28
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.28
Urgency of medical decision making	2.25	2.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.35	4.11
Physical effort required	4.00	3.72

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.05	3.78
Outcome depends on the skill and judgment of physician	4.30	3 94
Estimated risk of malpractice suit with poor outcome	4.45	3.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.83	3.44
Intra-Service intensity/complexity	3.89	3.83
Post-Service intensity/complexity	3.17	3.17

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AAOS and AAHKS convened an expert panel to develop a RVW recommendation for 27236 using survey data, National Surgical Quality Improvement Program (NSQIP) data, and CMS DRG data. The expert panel's rationale is discussed in detail below.

Pre-Service Time

The expert panel reviewed the pre-service time data from the RUC survey and agreed the times were appropriate. The expert panel noted that 60 minutes of evaluation time was higher as compared to other surgical procedures, but it was still within the range of evaluation time for 90-day global procedures. The expert panel believes the increased evaluation time for this procedure can be accounted for by the templating that is typically performed as part of the pre-service work. The 15 minutes of positioning time and 15 minutes of scrub, dress, wait time are typical for 90-day global procedures – especially with respect to orthopaedic procedures.

The expert panel recommends 90 minutes of total pre-service time for 27236, and specifically recommends 60 minutes evaluation, 15 minutes positioning, and 15 minutes scrub, dress, and wait time.

Intra-Service Time

The expert panel reviewed the intra-service time data from the RUC survey and noted the median time of 120 minutes. The expert panel looked to other objective sources of data in order to compare the survey times and develop appropriate recommendations.

The National Surgical Quality Improvement Project (NSQIP) is a national, validated, outcomes-based, risk adjusted program that measures aspects of surgical care. NSQIP intra-operative data indicate a median intra-operative time of 90 minutes for 27236, based on 1,932 patient records.

The expert panel recommends 90 minutes of intra-operative time for 27236 and bases this recommendation on its review of the data from the NSQIP database. The expert panel bases its recommendation on 1,932 actual cases from independent, national, hospital databases. The expert panel believes the voluminous intra-service data from the NSQIP database is considerably more reliable than the estimates of intra-service time collected from the RUC survey data.

Post-Service Time

The expert panel reviewed the immediate post-service time data from the RUC survey and agreed the 30 minutes indicated by survey respondents was appropriate. The expert panel noted the immediate post-service time for the reference code, 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*, is also 30 minutes. 30 minutes falls within the range of immediate post-service time for 90-day global procedures – especially with respect to orthopaedic procedures.

The expert panel recommends 30 minutes post-service time for 27236.

Hospital Visits

The expert panel reviewed the post-operative hospital visit data from the RUC survey and noted respondents believed 4 post-operative hospital visits (99231x1, 99232x2, and 99238x1) was typical. The expert panel compared the survey results with NSQIP data. The NSQIP data for 27236 indicates the total hospital length of stay (LOS) is 6 days. The NSQIP LOS data is based on 1,932 cases.

The expert panel recommends 6 hospital visits (99231x3, 992232x2, 99238x1) for 27236. The expert panel bases its 6-day hospital length of stay recommendation on NSQIP data from 1,932 cases.

Office Visits

The expert panel reviewed the post-operative office visit data from the RUC survey and agreed the number and intensity of office visits were appropriate. The expert panel noted this office visit pattern is identical to the reference code selected by survey respondents, 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*, which is a RUC-surveyed code. Both procedures share similar patterns of post-operative care with respect to the number and intensity of office visits.

The expert panel recommends 4 office visits (99213x3, 99212x1) for 27236.

RVW

The expert panel noted its pre-, intra-, and post-operative time recommendations reflect higher times than the existing Harvard data. The expert panel also noted the overall intensity measures were similar for 27236 and the most commonly selected reference code, 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*. The post-operative office visits for 27236 and the reference code (23472) were identical.

The expert panel noted there was a difference in the number of hospital visits from the Harvard data as compared to the survey data; however, they believed it was inappropriate to make this comparison for several reasons. First, when the Harvard hospital time (100 minutes) is compared with the Harvard number of hospital visits (99231x8, 99238x1), it suggests either a lower intensity visit was used for the Harvard study than is currently used by the RUC, or the number of visits were extrapolated from the total time. Second, it is unclear as to whether more than one visit per day was reported under the Harvard study. If this was the case, it is inconsistent with current RUC and CPT standards which allow a physician to report only one visit per day. Because of these methodological differences, the expert panel believes the Harvard hospital visit data cannot be compared with RUC survey data. The expert panel believes the NSQIP data accurately reflect the number and intensity of post-operative hospital visits, and also believes there has been no decrease in the amount work required for post-operative hospital care.

The expert panel noted the survey median RVW of 19.17 was a significant increase from the current RVW of 15.58. The median survey RVW suggests that survey respondents believe the overall work involved for this procedure has increased significantly. However, after consideration of the time, visit, and intensity factors, the **expert panel recommends maintaining the current RVW of 15.58 for 27236.**

IWPUT

The IWPUT calculations using the time and visit recommendations of the expert panel and the current RVW for 27236 is shown below.

IWPUT for 27236			**RVW**
		RVW:	**15.58**
	Data	**RUC Std.**	**RVW**
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	75	0 0224	1.34
Pre-service scrub, dress, wait	15	0 0081	0.16
Pre-service total			**1.80**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:		**E/M RVW**	**(=n x RVW)**
ICU 99291		4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233		1.51	0.00
99232	2	1.06	1.06
99231	3	0.64	1 92
Discharge 99238	1	1 28	1.28
Discharge 99239		1 75	0 00
99215		1.73	0 00
99214		1 08	0.00
99213	3	0.65	1.95
99212	1	0.43	0.00
99211		0.17	0.00
Post-service total			**8.37**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	90	**0.060**	5.41

The AAOS and AAHKS believe it is appropriate to maintain the current RVW of 15.58for 27236. Additionally, the AAOS and AAHKS recommend the time and visit data presented replace the Harvard data in the CMS and RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 49% No 51%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 89% less complex (less work) no change 11%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27236

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 3.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27447 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **21.45**
RUC RVU: **21.45**

CPT Descriptor: Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

CLINCIAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 69-year-old obese female (BMI > 30) with bilateral osteoarthritis of the knee joint presents with increased varus of the right knee affecting activities of daily living. She is hypertensive and a non-insulin dependent diabetic. At operation, she undergoes a conventional total right knee arthroplasty (TKA).

Percentage of Survey Respondents who found the Vignette to be Typical: 79%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Description of Pre-Service Work: 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 preoperative laboratory test; 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 templating of the case; 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.

Description of Intra-Service Work: After the tourniquet is elevated following exsanguination, an acceptable surgical incision is utilized to expose the joint. After everting the patella, appropriate soft tissue elevation and removal is performed to expose and visualize the joint. Care and attention is utilized to evaluate the ligament balance of the knee and appropriate soft tissue releases are performed to restore balance to the joint. The remnant meniscal tissue and overlying osteophytes are removed and if indicated, the cruciate ligaments are released. Next, attention is turned to the patella. The patella is measured and then the articular surface is resected at the appropriate depth. The optimal component size is selected and the fixation holes drilled. Next, attention is turned to the distal femur. The intramedulary canal is drilled and the distal femoral cutting block is applied. The alignment of the block is confirmed and the distal femoral resection is made. The AP and ML size of the distal femur is evaluated and the appropriate implant size selected following which the remaining chamfer and AP bone cuts of the distal femur are made. The remainder of the posterior cruciate ligament is excised to expose everything back to the capsule. This tissue is resected, taking great care to leave the collateral ligaments intact and protect the neurovascular structures. The tibia is subluxed forward and the tibial cutting guide is applied, the optimal position in all planes confirmed and the bone cut made. The tibia is sized for the appropriate implant and the bone prepared. Next, the trial components are inserted and a trial reduction of the prosthetic knee is performed. Overall limb alignment, soft tissue and ligamentous balance and prosthetic interactions are assessed. Further refinement of the soft tissue balance, the bone resections for alignment and the prosthetic implant interaction are performed as indicated to optimize the prosthetic longevity. The polyethylene insert into place onto the tibial prosthesis. Knee stability, range of motion and alignment are again confirmed. Having completed all of the preparations, the tourniquet is released, hemostasis obtained, a deep drain placed, and the wound closed in layers.

Description of Post-Service Work: Post-service begins after skin closure in the operating room and includes application of sterile dressing and extension splint or continuous Passive Motion apparatus (CPM). Post-operative 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, anticoagulation 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 sutures; evaluation of periodic imaging and laboratory reports, if needed; review of anticoagulation laboratory values and appropriate medication adjustment, 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 or outpatient care physical therapy as well.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005
Presenter(s):	Dale Blasier, MD, American Academy of Orthopaedic Surgeons Carlos Lavernia, MD, American Association of Hip and Knee Surgeons Brian Parsley, MD, American Association of Hip and Knee Surgeons Frank Voss, MD, American Association of Hip and Knee Surgeons
Specialty(s):	Orthopaedic Surgery
CPT Code:	27447
Sample Size: 500	**Resp n:** 42 **Response:** 8%
Sample Type: Random	

	Low	25th pctl	Median	75th pctl	High
RVW:	15.00	21.00	**21.50**	24.00	40.00
Pre-Service Evaluation Time:			**45**		
Pre-Service Positioning Time:			**15**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
ntra-Service Time:	60.00	70.00	**124**	100.00	180.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**87.0**	99231x **3.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**99.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **1.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
23472	090	21.07

CPT Descriptor Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	CPT Code: 27447	Key Reference CPT Code: 23472
Median Pre-Service Time	75	60.00
Median Intra-Service Time	124	165.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	87.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	99.0	84.00
Median Total Time	**451**	**443.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.55	2.92
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	3.08
Urgency of medical decision making	4.09	2.58

Technical Skill/Physical Effort (Mean)

Technical skill required	3.55	3.75
Physical effort required	3.73	3.42

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.45	3.67
Outcome depends on the skill and judgment of physician	3.82	3.83
Estimated risk of malpractice suit with poor outcome	3.91	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.91	3.08
Intra-Service intensity/complexity	3.55	3.50
Post-Service intensity/complexity	3.18	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The AAOS and AAHKS convened an expert panel to develop a RVW recommendation for 27447 using survey data, National Surgical Quality Improvement Program (NSQIP) data, and CMS DRG data. The expert panel's rationale is discussed in detail below.

Pre-Service Time

The expert panel reviewed the pre-service time data from the RUC survey and agreed the times were appropriate. The expert panel noted that 45 minutes of evaluation time was higher as compared to other surgical procedures, but it was still within the range of evaluation time for 90-day global procedures. The expert panel believes the increased evaluation time for this procedure can be accounted for by the templating that is typically performed as part of the pre-service work. The 15 minutes of positioning time and 15 minutes of scrub, dress, wait time are typical for 90-day global procedures – especially with respect to orthopaedic procedures.

The expert panel recommends 75 minutes of total pre-service time for 27447, and specifically recommends 45 minutes evaluation, 15 minutes positioning, and 15 minutes scrub, dress, and wait time.

Intra-Service Time

The expert panel reviewed the intra-service time data from the RUC survey and believed the median time of 90 minutes did not fully capture all of the intra-service time required for this procedure. As such, the expert panel looked to other objective sources of data in order to develop appropriate intra-service time recommendations.

The National Surgical Quality Improvement Project (NSQIP) is a national, validated, outcomes-based, risk adjusted program that measures aspects of surgical care. NSQIP intra-operative data indicate a median intra-operative time of 124 minutes for 27447, based on 10,365 patient records.

The expert panel also considered the CMS DRG database, which includes actual operating room time for 27447, compiled from automated hospital tracking software. This data was used by CMS in early 2005 to update the DRG for total joint arthroplasty under Medicare's Inpatient Prospective Payment System. The mean total operating room time for 2,916 total knee arthroplasty cases (27447) was 199.7 minutes. To estimate the skin-to-skin time, we subtracted the positioning time (20 minutes), scrub/dress/wait time (15 minutes), and a portion of the immediate post-time through discharge from recovery (20 minutes) from the total OR time (199.7 minutes) to arrive at an estimate of 144.7 minutes (199.7 – 55 = 144.7).

The expert panel recommends 124 minutes of intra-operative time for 27447 and bases this recommendation on its review of the data from these two large databases. The expert panel bases its recommendation on 13,281 actual cases from independent, national, hospital databases. The expert panel believes the voluminous intra-service data from the NSQIP and DRG database is considerably more reliable than the estimates of intra-service time collected from the RUC survey data.

Post-Service Time

The expert panel reviewed the immediate post-service time data from the RUC survey and agreed the 30 minutes indicated by survey respondents was appropriate. The expert panel noted the immediate post-service time for the reference code, 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*, is also 30 minutes. 30 minutes falls within the range of immediate post-service time for 90-day global procedures – especially with respect to orthopaedic procedures.

The expert panel recommends 30 minutes post-service time for 27447.

Hospital Visits

The expert panel reviewed the post-operative hospital visit data from the RUC survey and believed ,urvey respondents accurately identified the number and intensity of hospital visits required for this procedure. The expert panel validated the number of hospital visits indicated by survey respondents by comparing the survey results with two large databases. The expert panel noted that the survey results were consistent with the databases. The NSQIP data for 27447 indicates the total hospital length of stay (LOS) is 5 days. The NSQIP LOS data is based on 10,294 total knee arthroplasty cases. The CMS DRG database shows the mean hospital length of stay as 5 days. This data is based on 2,916 total knee arthroplasty cases.

The expert panel recommends 5 hospital visits (99231x3, 992232x1, 99238x1) for 27447. The expert panel bases its 5-day hospital length of stay recommendation on both RUC survey and actual data from 13,210 cases from independent, national hospital databases which confirmed the survey results. The expert panel agrees with survey respondents in the fact that one higher level hospital visit (99232) is appropriate because the initial hospital visit following surgery requires additional time and effort as compared to subsequent hospital visits. For example, the physician must address pain management, initiate DVT prophylaxis, and develop a PT regimen during this visit.

Office Visits

The expert panel reviewed the post-operative office visit data from the RUC survey and agreed the number and intensity of office visits were appropriate.

The expert panel recommends 4 office visits (99214x1, 99213x2, 99212x1) for 27447.

RVW

The expert panel noted its total time recommendation reflects higher times than the existing Harvard data. The expert panel also noted the overall intensity measures were similar for 27447 and the most commonly selected reference code, 23472 *Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))*. The post-operative office visit pattern for 27447 and the reference code (23472) were similar.

The expert panel noted there was a difference in the number of hospital visits from the Harvard data as compared to the survey data; however, they believed it was inappropriate to make this comparison for several reasons. First, when the Harvard hospital time (118 minutes) is compared with the Harvard number of hospital visits (99231x9, 99238x1), it suggests either a lower intensity visit was used for the Harvard study than is currently used by the RUC, or the number of visits were extrapolated from the total time. Second, it is unclear as to whether more than one visit per day was reported under the Harvard study. If this was the case, it is inconsistent with current RUC and CPT standards which allow a physician to report only one visit per day. Because of the methodological differences, the expert panel believes the Harvard hospital visit data cannot be compared with RUC survey data. The expert panel believes the current RUC survey and NSQIP data accurately reflect the number and intensity of post-operative hospital visits, and also believes there has been no decrease in the amount work required for post-operative hospital care.

The expert panel noted the survey median RVW of 21.50 was a slight increase from the current RVW of 21.45. The median survey RVW suggests that survey respondents believe the overall work involved for this ,rocedure has not significantly changed. After consideration of the time, visit, and intensity factors, the **expert panel agrees and recommends maintaining the current RVW of 21.45 for 27447.**

IWPUT

The IWPUT calculations using the time and visit recommendations of the expert panel and the current RVW for 27447 is shown below.

IWPUT for 27447			RVW
		RVW:	**21.45**
	Data	**RUC Std.**	**RVW**
Pre-service:	**Time**	**Intensity**	**(=time x intensity)**
Pre-service eval & positioning	60	0 0224	1.34
Pre-service scrub, dress, wait	15	0 0081	0.16
Pre-service total			**1.91**
Post-service:	**Time**	**Intensity**	**(=time x intensity)**
Immediate post	30	0.0224	0.67
Subsequent visits:		**E/M RVW**	**(=n x RVW)**
ICU 99291		4.00	0.00
ICU 99292		2.00	0.00
NICU 99296		16.00	0.00
NICU 99297		8.00	0.00
99233		1.51	0.00
99232	1	1.06	1.06
99231	3	0.64	1.92
Discharge 99238	1	1.28	1.28
Discharge 99239		1.75	0.00
99215		1 73	0.00
99214	1	1.08	0.00
99213	2	0.65	1.95
99212	1	0.43	0.00
99211		0.17	0.00
Post-service total			**7.74**
	Time	**IWPUT**	**INTRA-RVW**
Intra-service:	124	0.099	11.79

The AAOS and AAHKS believe it is appropriate to maintain the current RVW of 21.45 for 27447. Additionally, the AAOS and AAHKS recommend the time and visit data presented replace the Harvard data in the CMS and RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example).05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 79% No 21%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 90% I do not agree 91%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27447

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 2.0	
		99214: 1.0	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:27465 Global Period: 090 Specialty Society RVU: **17.50**
RUC RVU: **17.50**

CPT Descriptor: Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old motorcyclist has a symptomatic leg length discrepancy. He is brought to the operating room for femoral shortening to equalize the leg lengths.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The pre service begins after the decision is made to operate and is from the day before the surgery until the time of the procedure. This includes reviewing radiology images to assess the location of the planned osteotomies. These radiographic assessments are critical to planning the procedure. On the day of the surgery, the surgeon must meet with the patient and their family to explain the operative risks, benefits and obtain informed consent. The involved limb must be marked; history and physical may need to be updated. The range of motion of the hip and knee and neurovascular status must be assessed. The exact location of all previous scars must be identified. The length and rotation of the limb must be assessed on physical examination. Pre operative work will also include scrubbing nd supervising prepping and draping of the patient. All necessary equipment needs to be verified as available on the surgical table. The surgeon needs to ensure that C Arm fluoroscopy equipment is available during the procedure. Pre operative work up and pre operative laboratory values need to be reviewed.

Description of Intra-Service Work: The procedure begins by assessing the location for the planned osteotomy fluoroscopically. The osteotomy can be performed either closed or open. It needs to be a two level osteotomy and the levels of the two osteotomies need to be very carefully planned such the appropriate amount of bone is removed. An incision is made over the trochanter, the gluteus medius muscle is split and pyriformis fascias is identified. A wire is introduced into the proximal femur in the area of the fascia and its position is confirmed on AP and lateral fluoroscopic views. An entry reamer is then utilized to open the canal over the wire once its position is felt to be accurate. A long ball tip guide wire is passed down the femur and it is then assessed fluoroscopically to make sure its position is contained within the canal of the femur and the femur is sequentially reamed to accept the size nail that was pre operatively planned. An intramedullarly tool is then used to perform the two osteotomies, the position of which needs to be confirmed fluoroscopically. These are gradually performed using an expanding blade. Once the osteotomies are complete, the intermediate segment must be split with an intramedullarly cutting tool. During the osteotomies and the splitting the fragment, the control of the segments of the bone is done in a closed technique using continuous intra operative fluoroscopy. Once the femur is split, it can then be shortened by impacting the distal segment on the proximal segment, which moves the split intermediate segment away from the new proximal and distal segment of the bone. The appropriate sized intramedullarly nail is then passed over the wire to secure fixation over the now single osteotomy. The position of the split fragments is observed fluoroscopically as is the position of the nail, accurate length of the nail in relation to the shortened femur must be assessed. Care must be taken to make sure a rotation deformity is not created. This is assessed both fluoroscopically and clinically. Once all of these things have been assured to be correct, intramedullarly locking screws are placed after incisions are made and carried down to bone and proximal drilling is one through a gig to target the proximal locking hole. The appropriate length screw is then assessed fluoroscopically and with depth gauge and a screw is then placed across the nail as the position is assessed fluoroscopically. Distal screws are then targeted using intra operative imaging techniques to locate the holes in the center of the nail. Once this is accomplished, a small skin incision is made and a trochar tipped drill point is introduced down to the side of the bone

and tapped into position using continuous fluoroscopic guidance. The drill is then drilled across the hole through the opposite cortex, depth gauges and fluoroscopic control is used to assess the depth. An appropriate length screw is then placed and using a similar technique, a second , two intramedullarly locking screw is placed into position. The final construct is then assessed fluoroscopically. All wounds are closed in layers.

Description of Post-Service Work: Post service work begins after skin closure in the operating room and includes application of a sterile dressing to the wounds. Post operative work will include reviewing x-rays that are made after the procedure to assess the location of the implant, the contact of the osteotomy site and the alignment of the limb. Post operative work also includes: Monitoring patient's stabilization in the recovery room; communication with the family and other health professionals (including written and oral reports/orders); all hospital visits and services performed by the surgeon including monitoring lab reports; care and removal of the drains and dressings; supervision of post operative physical therapy; ordering and reviewing post operative x-rays; ordering and maintaining antibiotic and pain medications. Discharge day management includes the surgeon's final examination of the patient, instructions for continuation of care including home health care and preparation of discharge records. Post operative office visits for this service requires frequent follow up during the 90 degree global period. The patient will need to be initially assessed at two weeks to check status of the wound, make sure there is healing and to remove sutures. Patient needs to be closely monitored for pain and physical therapy and ability to regain knee and hip range of motion as well as quadriceps control needs to be assessed. In the second 6 weeks, radiographs are scrutinized to determine time to begin weight bearing and increase other activities. Close attention must be given to the position of the implant to make sure there is no change or evidence of failure. Pain medication needs to be adjusted during these post operative visits.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s).	Dale Blasier, MD, American Academy of Orthoapedic Surgeons Larry Marsh, MD, Orthopaedic Trauma Association David Volgas, MD, Orthopaedic Trauma Association					
Specialty(s):	Orthopaedic Surgery					
CPT Code:	27465					
Sample Size:	200	**Resp n:** 36		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		13.00	14.75	**17.50**	18.00	21.00
Pre-Service Evaluation Time:				**32.5**		
Pre-Service Positioning Time:				**20.0**		
Pre-Service Scrub, Dress, Wait Time:				**12.5**		
Intra-Service Time:		75.00	112.50	**120.00**	140.00	180.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**22.50**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**57.0**	99231x **3.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**76.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
27454	090	17.53

CPT Descriptor Osteotomy, multiple, with realignment on intramedullary rod, femoral shaft (eg, Sofield type procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 69.4 %

TIME ESTIMATES (Median)	CPT Code: 27465	Key Reference CPT Code: 27454
Median Pre-Service Time	65.00	60.00
Median Intra-Service Time	120.00	150.00
Median Immediate Post-service Time	22.50	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	57.0	57.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	76.0	92.00
Median Total Time	**376.50**	**425.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.60	3.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.25
Urgency of medical decision making	1.80	1.75

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	4.00
Physical effort required	3.80	3.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.60	3.75
Outcome depends on the skill and judgment of physician	3.80	3.75
Estimated risk of malpractice suit with poor outcome	3.60	3.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.80	3.75
Intra-Service intensity/complexity	3.60	3.75
Post-Service intensity/complexity	2.40	2.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
SEE ATTACHED RATIONALE

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 33% No

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27465

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 5.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:27470 Global Period: 090 Specialty Society RVU: **16.05**

RUC RVU: **16.05**

CPT Descriptor: Repair, nonunion or malunion, femur, distal to head and neck; without graft (eg, compression technique)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37-year-old male has sustained a fracture of the femur several months ago that has failed to heal properly in spite of good callus formation. He is taken to the operating room for repair.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The pre service begins after the decision is made to operate and is from the day before the surgery until the time of the procedure. This includes reviewing radiology images of the nonunion to assess its location, alignment and degree of stability. These radiographic assessments are critical to planning the procedure. If old hardware is present, the type of hardware must be identified and the surgeon must assure that there is appropriate equipment to remove it. This might necessitate a call to a local manufacturer's representative to have this equipment available. On the day of the surgery, the surgeon must meet with the patient and their family to explain the operative risks, benefits and obtain informed consent. The involved limb must be marked; history and physical may need to be updated. The range of motion of the hip and knee and neurovascular status must be assessed. The exact location of all previous scars must be identified. The length and rotation of the limb must be assessed on physical examination. Pre operative work will also include scrubbing and supervising prepping and draping of the patient. All necessary equipment needs to be verified as available on the surgical table. The surgeon needs to ensure that C Arm fluoroscopy equipment is available during the procedure. Pre operative work up and pre operative laboratory values need to be reviewed.

Description of Intra-Service Work: The skin incision begins the operation. This is typically through a previous incision, deep fascia and muscle layers are identified. The muscle is reflected anteriorly and bleeding is controlled. This may require clamping and ligating posterior perforating vessels which can cause considerable bleeding. The lateral side of the bone and the nonunion site are exposed. If there is previous hardware in place, it needs to be removed. This may require removing dense scar tissue or overgrown bone with sharp cutting instruments. If a previous intramedullarly nail is in place, it will need to be removed through separate incisions utilizing additional equipment. If hardware is broken, high speed instruments and fluoroscopic control may be necessary to open up the bone around broken implants and secure their removal. The nonunion site is then assessed. In this case, the extra callus will mostly be left in place and an attempt will be made to not disturb a majority of the soft tissue. If there is malalignment which is frequently the case, the nonunion will be mobilized enough to restore alignment. This often requires removing some tissue at then nonunion site and using osteotomes or other heavy bone instruments to increase mobility to allow the deformity to be corrected. The assessment of accurate correction occurs from direct exposure of the femoral shaft but also from fluoroscopic control in AP and lateral views. Once correction has been obtained, plans are made to place a laterally based implant. This is typically a broad heavy plate, extra bone along the lateral aspect of the femur may need to be removed to obtain a good fit and the plate may need to be contoured with bending instruments on the back table. Fluoroscopic control is necessary to insure accurate position of the implant and continued accurate alignment of the femoral nonunion site. Initial fixation is obtained with a single screw applied after pre drilling and tapping, to one end of the construct. The distal end is then brought against the plate, good contact is assessed under direct vision and the alignment is again assessed fluoroscopically. A second screw in the far end of the plate is placed after pre drilling and tapping. At this stage, the nonunion begins to be secure and again accurate alignment and contact of the implant must be assessed. Additional screw holes to increase stability are then filled after drilling and tapping with 4.5 mm screws applied both

proximally and distally. A minimum of four screws on each side of the nonunion site will be utilized. The nonunion is typically compressed by using the eccentric feature of the plate holes but sometimes extra external compression is obtained attaching another device to the plate fixed to the bone above or below the plate using a screw. Final position is assessed with intraoperative radiographs and if satisfactory, closure is in layers closing the deep muscle layer first, the fascia second, subcutaneous tissues third and then the skin. A deep drain is usually left in the deep layers

Description of Post-Service Work: Post service work begins after skin closure in the operating room and includes application of a sterile dressing to the wounds. Post operative work will include reviewing x-rays that are made after the procedure to assess the location of the implants, the contact of the nonunion site and the alignment of the limb. Post operative work also includes: Monitoring patient's stabilization in the recovery room; communication with the family and other health professionals (including written and oral reports/orders); all hospital visits and services performed by the surgeon including monitoring lab reports; care and removal of the drains and dressings; supervision of post operative physical therapy; ordering and reviewing post operative x-rays; ordering and maintaining antibiotic and pain medications. Discharge day management includes the surgeon's final examination of the patient, instructions for continuation of care including home health care and preparation of discharge records. Post operative office visits for this service requires frequent follow up during the 90 degree global period. The patient will need to be initially assessed at two weeks to check status of the wound, make sure there is healing and to remove sutures. Patient needs to be closely monitored for pain and physical therapy and ability to regain knee and hip range of motion as well as quadriceps control needs to be assessed. In the second 6 weeks, radiographs are scrutinized to determine time to begin weight bearing and increase other activities. Close attention must be given to the position of the plate to make sure there is no change or evidence of failure. Pain medication needs to be adjusted during these post operative visits.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Dale Blasier, MD, American Academy of Orthoapedic Surgeons Larry Marsh, MD, Orthopaedic Trauma Association David Volgas, MD, Orthopaedic Trauma Association					
Specialty(s):	Orthopaedic Surgery					
CPT Code:	27470					
Sample Size:	200	**Resp n:** 30		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		15.00	15.50	**16.00**	19.00	22.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		60.00	90.00	**120.00**	162.50	180.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**20.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**68.0**	99231x **2.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**83.0**	99211x **0.0** 12x **4.0** 13x **1.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
27580	090	19.34

CPT Descriptor Arthrodesis, knee, any technique

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 46.6 %

TIME ESTIMATES (Median)

	CPT Code: 27470	Key Reference CPT Code: 27580
Median Pre-Service Time	55.00	60.00
Median Intra-Service Time	120.00	150.00
Median Immediate Post-service Time	20.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	68.0	76.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	83.0	92.00
Median Total Time	**382.00**	**444.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	4.00
Urgency of medical decision making	2.00	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.25	4.00
Physical effort required	4.00	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	3.00
Outcome depends on the skill and judgment of physician	4 00	3 00
Estimated risk of malpractice suit with poor outcome	3.75	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.67	3.00
Intra-Service intensity/complexity	3.33	3.00
Post-Service intensity/complexity	4.00	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SEE ATTACHED RATIONALE

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0 05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 25% No

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27470

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 5.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 4.0	
		99213: 1.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:27709 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **19.00**
RUC RVU: **16.50**

CPT Descriptor: Osteotomy; tibia and fibula

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 22-year-old man has a deformity of the tibia which interferes with activities of daily living. He is brought to the operating room for correction of the deformity.

Percentage of Survey Respondents who found Vignette to be Typical: 66%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The pre service begins after the decision is made to operate and is from the day before the surgery until the time of the procedure. This includes reviewing radiology images to assess the location, alignment and degree of deformity. These radiographic assessments are critical to planning the procedure. If old hardware is present, the type of hardware must be identified and the surgeon must assure that there is appropriate equipment to remove it This might necessitate a call to a local manufacturer's representative to have this equipment available. On the day of the surgery, the surgeon must meet with the patient and their family to explain the operative risks, benefits and obtain informed consent. The involved limb must be marked; history and physical may need to be updated. The range of motion of the hip and knee and neurovascular status must be assessed. The exact location of all previous scars must be dentified. The length, rotation and alignment of the limb must be assessed on physical examination. Pre operative work will also include scrubbing and supervising prepping and draping of the patient. All necessary equipment needs to be verified as available on the surgical table. The surgeon needs to ensure that C Arm fluoroscopy equipment is available during the procedure. Pre operative work up and pre operative laboratory values need to be reviewed.

Description of Intra-Service Work: The procedure begins with an incision over the deformity site. This is carried down to the subcutaneous border of
the tibia and the tibia is exposed through 180 degree circumference. Retractors are placed to
protect neurovascular structures. The planned area for the osteotomy is then assessed and confirmed
fluoroscopically. This will usually require intraoperative correlation with pre operative imaging studies and pre operative planning drawings. Depending on the type of osteotomy that has been planned, a wedge of bone may need to be removed to correct the deformity. If this is contemplated, it needs to be marked onto the exposed tibia based on pre operative planning and imaging studies. Prior to actually beginning the correction, an additional 5 cm incision is made over the lateral aspect of the leg and split down through the muscle planes. A sharp incision is made onto the fibula and it is exposed with retractors on the far side. A small oscillating saw is
used to osteotomize the fibula and a second osteotomy 1 cm distally is accomplishing removing
1 cm of bone. The site is inspected to make sure the fibular osteotomy is complete. Attention is now returned to the tibia and the planned osteotomy is made with sharp bone tools and power instruments. Usually, a considerable degree of carpentry is necessary to make the appropriate cuts free interfering soft tissues and bony specula's to allow an adequate correction. The degree to which correction is obtained is initially assessed with fluoroscopic images to determine the position of the knee and ankle and alignment of the shaft in AP and lateral planes. However, intra operative AP and lateral tibia x-rays are often obtained to determine that there is accurate correction. Direct visual inspection of the osteotomy site assures good contact. If any of these assessments do not appear to e accurate, the bone cuts are refined with further bone or power instruments. When everything is correct, fixation is obtained across the osteotomy. This might be done with a 4.5 mm compression plate. This is applied to the exposed surface of the tibia. The bone or the implant may need to be contoured with either power instruments or a bending press respectively. When an accurate fit of the implant is obtained to the corrected bone, it is fixed with an

initial 4.5 mm screw proximally after pre drilling and tapping. A second screw is then applied distally. Again, intra operative fluoroscopy and perhaps radiographs are necessary to confirm accurate alignment. When this is assured, further stability is obtained with proximal and distal screw fixation, usually with up to 4 screws applied both proximally and distally. Depending on the planning of the osteotomy an interfragmentary screw across the osteotomy site may be applied after pre drilling. If this technique is chosen the proximal fragment of the bone is over drilled with a larger drill. The limb is inspected externally to assess correction of the deformity and rotation of the limb. When everything is felt to be satisfactory, closure is in 2 layers with subcutaneous tissues and skin.

Description of Post-Service Work: Post service work begins after skin closure in the operating room and includes application of a sterile dressing to the wounds. Post operative work will include reviewing x-rays that are made after the procedure to assess the location of the implants, the contact of the osteotomy site and the alignment of the limb. Post operative work also includes: Monitoring patient's stabilization in the recovery room; communication with the family and other health professionals (including written and oral reports/orders); all hospital visits and services performed by the surgeon including monitoring lab reports; care and removal of the drains and dressings; supervision of post operative physical therapy; ordering and reviewing post operative x-rays; ordering and maintaining antibiotic and pain medications. Discharge day management includes the surgeon's final examination of the patient, instructions for continuation of care including home health care and preparation of discharge records. Post operative office visits for this service requires frequent follow up during the 90 degree global period. The patient will need to be initially assessed at two weeks to check status of the wound, make sure there is healing and to remove sutures. Patient needs to be closely monitored for pain and physical therapy and ability to regain knee and hip range of motion as well as quadriceps control. In the second 6 weeks, radiographs are scrutinized to determine time to begin weight bearing and increase other activities. Close attention must be given to the position of the implants to make sure there is no change or evidence of failure and that the corrected alignment is maintained. Pain medication needs to be adjusted during these post operative visits.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Dale Blasier, MD, American Academy of Orthoapedic Surgeons Larry Marsh, MD, Orthopaedic Trauma Association David Volgas, MD, Orthopaedic Trauma Association					
Specialty(s):	Orthopaedic Surgery					
CPT Code:	27709					
Sample Size:	200	**Resp n:** 36		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		10.00	16.50	**16.50**	21.00	21.00
Pre-Service Evaluation Time:				**40.0**		
Pre-Service Positioning Time:				**17.5**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		45.00	107.50	**107.50**	170.00	180.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**15.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**38.0**	99231x **2.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**76.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

CPT Code:

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
27725	090	15.57

CPT Descriptor Repair of nonunion or malunion, tibia; by synostosis, with fibula, any method

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 61.1 %

TIME ESTIMATES (Median)	CPT Code: 27470	Key Reference CPT Code: 27725
Median Pre-Service Time	67.50	60.00
Median Intra-Service Time	160.00	150.00
Median Immediate Post-service Time	15.00	30.00
Median Critical Care Time	0 0	0.00
Median Other Hospital Visit Time	38.0	57.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	76.0	122.00
Median Total Time	**392.50**	**455.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.67
Urgency of medical decision making	2.50	2.67

Technical Skill/Physical Effort (Mean)

Technical skill required	4.17	3.83
Physical effort required	3.67	3.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.83	3.67
Outcome depends on the skill and judgment of physician	4.00	3.67
Estimated risk of malpractice suit with poor outcome	4.17	3.83

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.17	3.67
Intra-Service intensity/complexity	4.17	3.83
Post-Service intensity/complexity	3.00	3.33

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

SEE ATTACHED RATIONALE

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 50% No

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 27709

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 4.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:29075 Global Period: 000 Specialty Society RVU: **0.89**

RUC RVU: **0.77**

CPT Descriptor: Application, cast; elbow to finger (short arm)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 18-year-old male has a cast applied from below elbow to palm as treatment for an undisplaced wrist fracture.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Imaging studies are carefully reviewed including X-rays, CT scans, and MRIs.
- Consultation is completed with the referring physician and other healthcare professionals
- The family and patient are apprised of the proposed procedure.
- The risks and complications associated with the procedure are discussed with the family.

Description of Intra-Service Work: A cast is applied from below elbow to the palm, including applying the padding. While the casting material is setting, the cast is molded to maintain anatomic position of the fracture without compromising the skin or neurovascular structures.

Description of Post-Service Work:
- Comfort of the patient is assessed.
- The mobility and neurovascular status of the hand and fingers are assessed.
- The patient is instructed in the care of the casted upper extremity and followup is scheduled.
- Consultation with consultants and other healthcare professionals are completed (both written and verbal).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Dale Blasier, MD, American Academy of Orthopaedic Surgeons					
Specialty(s):	Orthopaedic Surgery					
CPT Code:	29075					
Sample Size:	200	**Resp n:** 30		**Response:** 15.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.58	0.87	**0.89**	0.90	0.94
Pre-Service Evaluation Time:						
Pre-Service Positioning Time:						
Pre-Service Scrub, Dress, Wait Time:						
Intra-Service Time:			0.00			0.00
Post-Service	**Total Min****	**CPT code / # of visits**				

CPT Code:

Immed. Post-time:	____	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
29085	000	0.87

CPT Descriptor Application, cast; hand and lower forearm (gauntlet)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
	000	

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 70.0 %

TIME ESTIMATES (Median)	**CPT Code: 29075**	**Key Reference CPT Code: 29085**
Median Pre-Service Time	15.00	8.00
Median Intra-Service Time	10.00	25.00
Median Immediate Post-service Time	5.00	9.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**30.00**	**42.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.20	2.20
Urgency of medical decision making	2.40	2.40

Technical Skill/Physical Effort (Mean)

Technical skill required	3.20	3 20
Physical effort required	2.60	2.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.40	2.40
Outcome depends on the skill and judgment of physician	2.80	2.80
Estimated risk of malpractice suit with poor outcome	2 60	2.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.80	2.80
Intra-Service intensity/complexity	3.00	3.00
Post-Service intensity/complexity	2.20	2.20

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Academy of Orthopaedic Surgeons (AAOS) collected survey data for 29075 because CMS selected it for the current five-year review. The AAOS reviewed the survey data for 29075 and believed the intra-service time was low because it often takes more than 10 minutes for the cast material to set. However, the AAOS believed the intensity values of the survey code compared to the reference code (29085) most often selected by respondents was reasonable. As such, the AAOS believes the survey median RVW represents an appropriate value.

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CMS indicates 29075 billed with EM 32% of time

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes No 0%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) less complex (less work) no change 100%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 29075

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		23.00	
Clinical Staff #1	Staff Type: RN/LPN/MA	Intra Assist Physician Time: 15.0	Staff % of Physician time 65%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		23.0	
Clinical Staff #1	Staff Type: RN/LPN/MA	Intra Assist Physician Time: 15.0	Staff % of Physician time **Change:** **In Time** 65% 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64702 | Global Period: 090 | **Recommended Work Relative Value**
Specialty Society RVU: **6.00**
RUC RVU: **5.52**

CPT Descriptor: Neuroplasty; digital, one or both, same digit

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old laborer who is status post repair of the small finger ulnar digital nerve undergoes a neurolysis of the ulnar digital nerve of the small finger.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Consultation is completed with the referring physician and other healthcare professionals
- Reexamine patient to make sure that physical findings have not changed and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: A combination of mid lateral and Bruner incisions is made to expose the small finger ulnar digital neurovascular bundle. The incision is carried extended into the palm to normal tissue. The ulnar digital nerve of the small finger is identified and meticulously dissected from proximal to distal. Great care is taken to not injure the nerve and carefully release it from its adhesions to the adjacent subcutaneous tissue and underlying flexor tendon and ulnar digital artery. Once the neurovascular bundle is identified, a neurolysis is completed, moving from proximal to distal. Meticulous hemostasis is carried out throughout procedure using bipolar electrocautery. Once the neuroplasty has been completed, the wound is thoroughly irrigated and then closed using interrupted sutures.

Description of Post-Service Work:
Post-service work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.

- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Postoperative imaging studies and labs are reviewed
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.
- Dictation of an operative report
- Procedure note is written in the patient chart

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Nagle, MD;					
Specialty(s):	hand surgery;					
CPT Code:	64702					
Sample Size:	150	**Resp n:** 45		**Response:** 30.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		4.00	5.00	**6.00**	6.50	9.00
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		25.00	45.00	**50.00**	60.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**20.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**				
Office time/visit(s):	**76.0**	99211x **0.0** 12x **2.0** 13x **2.0** 14x **0.0** 15x **0.0**				

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41), 99232 (30), 99231 (19); 99238 (36); 99215 (59), 99214 (38), 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
64704	090	4.56

CPT Descriptor Neuroplasty; nerve of hand or foot

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 70.0 %

TIME ESTIMATES (Median)	CPT Code: 64702	Key Reference CPT Code: 64704
Median Pre-Service Time	45.00	35.00
Median Intra-Service Time	50.00	56.00
Median Immediate Post-service Time	20.00	18.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0 0	0.00
Median Discharge Day Management Time	18 0	0.00
Median Office Visit Time	76.0	38.00
Median Total Time	**209.00**	**147.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2 79	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 26	2 68
Urgency of medical decision making	2.63	2.41

Technical Skill/Physical Effort (Mean)

Technical skill required	2 92	3.79
Physical effort required	2.69	2.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.21	2 95
Outcome depends on the skill and judgment of physician	3.84	3 74
Estimated risk of malpractice suit with poor outcome	2.80	3.05

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2 69	3.04
Intra-Service intensity/complexity	3.27	3.54
Post-Service intensity/complexity	2.62	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The RVW for code 64702 Neuroplasty; digital, one or both, same digit is based on Harvard time and visit data, which ve do not believe are accurate. The Harvard pre-service time is low compared with other hand surgery codes. No time was allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder. Additionally, only two postoperative office visits are included in the database, which is significantly less than the typical four or more visits necessary. This procedure is typically performed in an outpatient setting, requiring return of the patient to the surgeon's office within a few days of the surgery for a

wound check, dressing change, and referral to occupational therapy. The second office visit is typically for suture removal, wound check, and assessment of therapy requirements. The remaining office visits include assessment of nerve healing and range of motion.

Discussion: CPT 64704 Neuroplasty; nerve of hand or foot was cited most often as a reference for 64702 Intra-operative work (time and intensity) is similar for both procedures, which involve dissection of neurovascular structures Pre-service and post-service facility work will be similar.

Our consensus panel analyzed the current RVW (4.58) with the current survey data. The result was a negligible IWPUT (0.002). As stated above, the Harvard pre-service time is low compared with other hand surgery codes. No time was allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder.

The survey median RVW of 6.00 results in an IWPUT of 0.038, which is slightly greater than an E/M service. This value is less than 24332 Tenolysis, triceps (RVW=7.44) and 25652 Open treatment of ulnar styloid fracture (RVW=7.59), which are two hand surgery codes that have been reviewed by the RUC that have similar time and visit profiles.

We are recommending the median RVW of 6.00 for 64702. We also ask that the time and visit details from our full RUC survey replace the Harvard data in the RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 8% No 93%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 33% I do not agree 67%
B. Patients requiring this service are now:

more complex (more work) 67% less complex (less work) 0% no change 33%

C. The usual site-of-service has changed:
from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 0.5	
Number and Level of Office Visits:		99211:	
		99212: 2.0	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 2.0	
		99213: 2.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:64721 Global Period: 090 Specialty Society RVU: **5.00**
RUC RVU: **4.28**

CPT Descriptor: Neuroplasty and/or transposition; median nerve at carpal tunnel

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman with carpal tunnel syndrome undergoes an open carpal tunnel release.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs
- Consultation is completed with the referring physician and other healthcare professionals
- Reexamine patient to make sure that physical findings have not changed and update H&P
- Meet with patient and family to review planned procedure and post-operative management
- Review informed consent with patient
- Verify that all required instruments and supplies are available
- Monitor/assist with patient positioning; padding of bony prominences; and application of thermal regulation drapes
- Assess position of the extremities and head, adjust as needed
- The patient's arm is placed on the hand surgery table.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is applied to the proximal arm.
- The arm and hand are prepped and draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made along the ulnar border of the carpal tunnel in the palm. Careful dissection is carried out. The branches of the palmar cutaneous branch of the median nerve, as well as the palmar cutaneous branch of the ulnar nerve, are identified and protected. The transverse carpal ligament is carefully identified. The proximal and distal edges of the transverse carpal ligament are identified. A groove director is placed in the carpal tunnel along its ulnar border. A #15-blade is then used to incise the transverse carpal ligament along its ulnar border. Care is taken not to injure the underlying flexor tendons or the branches of the median or ulnar nerve. Care is taken to protect the superficial palmar arch and the communicating sensory branches between the median and ulnar nerves which course just distal to the transverse carpal ligament. Once the transverse carpal ligament is released, the contents of the carpal tunnel are examined including the flexor tendons and the median nerve. If needed, an external neurolysis of the median nerve is carried out. The wound is thoroughly irrigated. The skin is then approximated using an interrupted suture.

Description of Post-Service Work:
Post-service work: in hospital

- Application of dressing and splint.
- Monitoring patient stabilization in the recovery room.
- Consultation with the family and patient regarding the surgery and postoperative regimen.
- Communication with health care professionals including written and oral reports and orders.
- Postoperative care is coordinated with recovery room nursing staff.
- The patient's vital signs are checked.
- The circulation, sensation and motor function of the operated extremity are assessed.
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Write prescriptions for medications needed post-discharge.
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.
- Dictation of an operative report
- Procedure note is written in the patient chart

Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of splint/dressings
- Assessment of surgical wound
- Remove sutures
- Assess of circulation, sensation and motor function of the operated extremity
- Redress wound
- Order occupational therapy
- Supervision of rehabilitation
- Discuss progress with PCP (verbal and written)
- Write medication prescriptions
- Dictate progress notes for medical record

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Daniel Nagle, MD; Dale Blasier, MD					
Specialty(s):	hand surgery; orthopaedic surgery, plastic surgery					
CPT Code:	64721					
Sample Size:	150	**Resp n:** 39		**Response:** 26 0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		3.00	5.00	**5.00**	5.50	7.20
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		10.00	16.00	**25.00**	30.00	45.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**20.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**61.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
64719	090	4.84

CPT Descriptor Neuroplasty and/or transposition; ulnar nerve at wrist

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 58.9 %

TIME ESTIMATES (Median)	CPT Code: 64721	Key Reference CPT Code: 64719
Median Pre-Service Time	45 00	34.00
Median Intra-Service Time	25.00	61.00
Median Immediate Post-service Time	20.00	17.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	61.0	38.00
Median Total Time	**169.00**	**150.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.06	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.94	3.06
Urgency of medical decision making	2.31	1.94

Technical Skill/Physical Effort (Mean)

Technical skill required	3.05	3.06
Physical effort required	2.89	2.19

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2 05	3.00
Outcome depends on the skill and judgment of physician	2 95	3.38
Estimated risk of malpractice suit with poor outcome	2.05	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.06	2.89
Intra-Service intensity/complexity	2.50	3.63
Post-Service intensity/complexity	2.39	3.61

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
CMS nominated code 64721 for review during this 5YR. This code was reviewed during the first 5YR, but the RUC rejected the recommendation because "intra-service time is similar to Harvard data. No other compelling evidence to increase the current value was presented." Therefore, the current time and visit data are Harvard-based.

Discussion: CPT 64719 Neuroplasty and/or transposition; ulnar nerve at wrist was cited most often as a reference for 64721 Neuroplasty and/or transposition; median nerve at carpal tunnel. Intra-operative Harvard time for 64719 is

greater than 64721 as an ulnar nerve neuroplasty at the wrist requires dissection of the ulnar artery and nerve from three centimeters proximal to the wrist flexion crease well into the palm. This extended exposure and dissection of the ulnar neurovascular bundle requires more time for exposure, dissection, and closure. The Harvard pre-service time is low compared with other hand surgery codes. No time was allocated for prepping and positioning the hand prior to surgery, which includes exsanguination of the limb and positioning the hand and fingers on a hand holder. Pre-service and post-service facility time and work would be very similar.

Our consensus panel analyzed the current RVW (4.28) with the current survey data. The result was an IWPUT of 0.024. This is intensity is less than an E/M service and is not reasonable for a procedure that involves vital neurovascular structures in the hand. One millimeter error can result in permanent neurological impairment of the hand. The survey median RVW of 5.00 results in an IWPUT of 0.053. This intensity is greater than an E/M service and less than ICU care and we believe fairly represents the intensity of this delicate procedure. We are recommending the median RVW of 5.00 for 64721. We also ask that the time and visit details from our full RUC survey replace the Harvard data in the RUC database.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 36% No 64%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 31% I do not agree 69%
B. Patients requiring this service are now:
   more complex (more work) 92% less complex (less work) 0% no change 8%
C. The usual site-of-service has changed.
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 0.5	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 2.0	
		99214:	
		99215:	

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Recommendations – Gynecology/Urology/Pain Medicine/Neurosurgery

Obstetrics and Gynecology

The American College of Obstetrics and Gynecology (ACOG) expressed an interest in developing RUC recommendations for 20 codes for the Five Year Review. Of the 20 codes, ACOG withdrew 10 codes from the consent calendar and Centers for Medicare and Medicaid Services (CMS) withdrew one code, 58260. Of the remaining codes, four codes (57500, 58120, 58150 and 58720) were identified by CMS because the service has never been reviewed by the RUC or the service has experienced a change in technology. The remaining codes (57160, 57240, 57250, 57260 and 57265) were identified by the ACOG because of changes in technology, anomalous relationships between existing codes and because the service has never been reviewed by the RUC. Of the remaining nine codes, ACOG did not believe the work values accurately reflected the amount of physician work for seven codes and recommended to maintain the values of two codes. For all nine codes, a full RUC survey was utilized.

Of the nine codes presented with survey data, the RUC valued six codes, but below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued due to compelling evidence such as rank-order anomalies, changes in patient population and incorrect assumptions were made in the previous valuation of the service. The RUC maintained the existing RVUs for three codes. For one of the three codes (57160), the RUC felt there was a lack of compelling evidence to change the RVU and for the other two codes (58120 and 58720), the RUC agreed with the specialty society that the survey data collected validated the existing times and existing RVUs.

Urology

The American Urological Association (AUA) expressed an interest in developing RUC recommendations for 12 codes for the Five Year Review. Of the 12 codes, the Coalition for the Advancement of Prosthetic Urology (CAPU), the original commenter, withdrew four codes from the consent calendar. Of the remaining eight codes, seven codes (50590, 51720, 52000, 52204, 52601, 55700 and 57288) were identified by CMS because of changes in technology or the service has never been reviewed by the RUC. The remaining

code, 51798 was identified by the AUA to reaffirm its recommendation to CMS. AUA did not believe the work values accurately reflected the amount of physician work for six codes and recommended to maintain the values of two codes. For all eight codes, a full RUC survey was utilized.

Of the eight codes presented with survey data, the RUC accepted one of the specialty society's recommendations to increase the existing RVUs. This procedure, 51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging, originally was reviewed by the RUC in April 2002. The RUC approved 0.38 work RVUs to reflect the physician work associated with this procedure. The RUC at this time would like to reaffirm the previous RUC recommendation of 0.38 work RVUS for this procedure.

The RUC increased five codes below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued due to changes in technology, changes in patient populations and incorrect assumptions were made in the previous valuation of the service. The RUC maintained the existing RVUs for two codes. For one of the two codes, The RUC felt that the work currently associated with the code is accurate and for the other code the RUC agreed with the specialty society that the survey data collected validated the existing RVUs.

Spine Surgery

The North American Spine Society (NASS) with several other specialty societies including American Society of Neuroradiology, Society of Interventional Radiology, American Academy of Orthopaedic Surgeons, American Association of Neurological Surgeons and the American College of Radiology, expressed an interest in developing RUC recommendations for seven codes, 22520, 22554, 22612, 22840, 63047, 63048 and 63075. These seven codes were identified by CMS because of changes in technology or because the RUC never reviewed this service. Of the seven codes, NASS did not believe the work values accurately reflected the amount of physician work for 5 codes the codes and recommended to maintain the work of two codes. For these seven codes the NASS utilized an alternative methodology approved by the Research Subcommittee and the RUC. This alternative methodology is as follows: The North American Spine Society (NASS) requested to use a modified and shortened RUC survey for seven codes in an attempt to increase the response rate. Because these are high volume codes and because these codes are linked to many other spine surgery codes, NASS wanted to survey a large number of surgeons and felt that the existing RUC survey would not result in a high response rate. NASS proposed a modified version of the standard RUC survey that will gather traditional RUC time data for the pre, intra, and

post service periods for each of the seven codes. For intensity and complexity, however, NASS will collect data on the changes that have occurred during the past 5-10 years in the performance of these procedures rather than the absolute numbers collected by the standard RUC survey. The Research Subcommittee had a number of concerns with this approach due to the lack of comparison with reference codes. The Subcommittee modified the proposed methodology so that reference codes are incorporated in the methodology. The Research Subcommittee suggested that the specialty utilize the modified survey but the survey should include two reference services that will be surveyed so the data can be compared to reference services. In addition the survey would include the intensity questions from the RUC survey but the survey respondents will be asked to indicate the changes if any during the past 5-10 years in the complexity and intensity for each component. The research subcommittee recommended approval of the following alternative methodology for NASS:

The specialty may use a modified RUC survey for codes 22520, 22554, 22612, 22840, 63047, 63048, and 63075 that will include surveys of time (pre, intra-service, immediate post-service), post op visits and estimates of total work. In the table surveying changes in intensity and complexity, two reference codes will be included and surveyed.

NASS conducted its survey online and quarantined the initial 14 web-based responses based on feedback from the RUC. The feedback was specific to two issues. One was the usage of language in the length of stay section (Survey question #3). The exact text seen in the 14 quarantined surveys was:

- Please estimate post-operative facility E&M services for the typical patient undergoing these procedures. (Refer to E&M code definitions provided on previous page.) The total number of visits identified below should add up to the number listed in question 2 (or less if you do not typically see the patient on the hospital floor the same day post op).
- Use a discharge service code (99238 and 99239) on discharge day if services you provide meet the definitions:

  Example 1: If LOS is 10 days; you might indicate, post op visit= 99231; and 99232=8 and 99238 on day of discharge
  Example 2: If LOS is 3 days; you might indicate, post op visit= none, and 99231=2; and 99238 on day of discharge
  Example 3: If outpatient; you might indicate 99238

The other issue involved the use of a default setting to "yes" for survey question #7 which queries if the vignette describes the typical patient. NASS removed the above text from question #3 and changed question #7 so there was no default setting on their web-based

survey. Their results from the quarantined surveys account for a very small percentage of their overall survey respondents. The RUC agreed with the specialty society that for this reason any difference between quarantined and non-quarantined results had no effect on the total results. The RUC also commended the specialty society in the manor in which they handled this issue.

The RUC accepted three of the specialty society's recommendations to decrease the existing RVUs for three procedures. The RUC agreed with the specialty society that these procedures were overvalued due to changes in length of stay and changes in physician time. The RUC accepted the specialty society's recommendation to maintain the work associated with two codes. The RUC agreed with the specialty society that the survey data collected validated the existing RVU associated with these codes. The RUC increased two codes below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures were undervalued due to changes in length of stay and incorrect assumptions were made in the previous valuation of the service.

Spinal Pump Infusion and Stimulators

The American Academy of Pain Medicine (AAPM), North American Spine Society, American Association of Neurological Surgeons and the American Society of Anesthesiologists (ASA) expressed an interest in developing RUC Recommendations for 26 codes. AAPM and ASA, as the original commenters, withdrew all of these codes from the Five Year Review.

Aneurysm, Epilepsy and Skull Procedures

The American Association of Neurological Surgeons (AANS) expressed an interest in developing RUC recommendations for eight codes. Of these eight codes, four codes (61697, 61698, 61700, 61702) were identified by AANS because of changes in technique, technology and length of hospital stay and two codes (61537 and 61538) were identified by AANS because of an anomalous relationship between these codes and other codes within the craniotomy family. The remaining two codes (61154 and 61312) were identified by CMS because the service have never been reviewed by the RUC or because of advances in technology. For all eight codes, AANS did not believe the work values accurately reflected the amount of physician work for seven codes and recommended to maintain the work of one code. For the eight codes, a full RUC survey was utilized.

The RUC accepted three of the specialty society's recommendations to increase the existing RVU for three codes (61312, 61537 and 61538). The RUC agreed with the specialty society that this procedure is undervalued due to a change in the patient population and felt that survey results validated an appropriate increase. The RUC increased four codes (61697, 61698, 61700 and 61702) but below the level recommended by the specialty society. The RUC agreed with the specialty society that these procedures are undervalued due to change in technique, technology and length of hospital stay. The RUC maintained the existing RVUs for the remaining code (61154) as it felt that the work currently associated with this procedure is accurate.

AMA/Specialty Society RVS Update Committee
RBRVS 2005 Five-Year Review
RUC Recommendations - Gynecology/Urology/Pain Medicine and Neurosurgery

CPT Code	*Descriptor*	*2005 work RVU*	*RUC Rec Work RVU*	*Comment from the Public*	*RUC Rationale*	*Change in Time from 2005?*	*Action Key*
22520	PERCUT VERTEBROPLASTY THOR	8.90	8.90	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure	The RUC reviewed the survey data and made modifications to the pre-service time associated with this code to mirror the reference code 22523 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation; thoracic (Work RVU=8.94). The RUC agreed that there was slightly more work associated with the reference code as compared to this procedure Therefore, the RUC feels that the 25th percentile of the survey, 8.89 work RVUs, supports the recommendation to maintain the value of this code at 8 89 work RVUs. The discharge day management service was reduced from a full visit to half a visit to be in compliance with the RUC standard regarding outpatient procedures. The RUC also requests that this half day discharge visit should be applied to the reference code, 22523, as well, In addition the RUC recommends that the language, fracture reduction and bone biopsy	☑	2

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Action Key (1 = Adopt the recommended increase in the work RVU, 2 = Maintain the current work RVU; 3 = Adopt the recommended decrease in the work RVU; 4 = Suggest a new RVU; 5 = Refer the code to CPT, 6 = No consensus, 7 = Accept withdrawal by commenter, without prejudice; 8 = No Level of Interest submitted, no Recommendation submitted)

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
					included when performed, should be added to this 22520 to mirror the language of other codes in this family.		
22554	NECK SPINE FUSION	18.59	16 40	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the length of stay The RUC reviewed the specialty society's survey results and observed that the intra-service time for this procedure as it is currently provided is 30 minutes less than what is currently associated with the procedure. However, the specialty society noted that this shorter time is associated with a higher intensity. Therefore the RUC to accommodate this shorter time with a higher intensity, agreed with the specialty society's recommendation of 16.40 work RVU's which properly rank orders the current higher intensity of the intra-service time as compared to the intra-service intensity of the this procedure in the past The RUC recommends the median pre-, intra- and post-service times and 16.40 work RVU for 22554	☑	3

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
22612	LUMBAR SPINE FUSION	20 97	22.00	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the length of hospital stay. The RUC reviewed the survey data and recommends the median pre-, intra- and post-service times as they are felt to be congruent with the work being performed. However, the RUC believed that the 25th percentile of 22.00 work RVUs is a more appropriate value for this procedure as it properly ranks this code with the reference code, 22595 Arthrodesis, posterior technique, atlas-axis (C1-C2) (Work RVU=23 36) which has slightly higher times and intensity measures.	☑	4
22840	INSERT SPINE FIXATION DEVICE	12 52	12.52	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The RUC reviewed the survey results and noted that the median intra-service time is the same as the current intra-service time, 60 minutes. However, the RUC agreed with the specialty society that the median survey value for this procedure was inflated. The specialty society stated that this was due to the respondent feeling that the intensity and complexity of the procedure had increased The RUC and the specialty society recommend to maintain the current value for this procedure at 12.52 work RVUs	☐	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
49200	REMOVAL OF ABDOMINAL LESION	10.23		ACOG commented that 49200 is similar to 58952, which includes 58950 plus radical dissection for debulking	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
49201	REMOVE ABDOM LESION, COMPLEX	14.82		ACOG commented that 49201 is similar to 58952, which includes 58950 plus radical dissection for debulking	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
50590	FRAGMENTING OF KIDNEY STONE	9.08	9 08	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure	The RUC agreed with CMS that the technology to perform this procedure has changed. The specialty society explained that the older technology which used a higher shock wave frequency to reduce procedure time, therefore the frequency was often more painful for the patient Current technology employs a lower shock wave frequency which takes longer but reduces potential pain for the patient. Therefore, the RUC recommends the 75th percentile of 60 minutes intra-service time, for this procedure which is less than existing intra-service time but maintains that the current value, 9 08 work RVUs, for the procedure is appropriate and validated by the survey This value is also appropriate when compared to the reference code 53850 Transuretheral destruction of prostate tissue, by microwave therapy (Work RVU =9.43) as times and intensities for both procedures are similar. The RUC recommends half a discharge day management and eliminating the specialty society recommended subsequent hospital day (99231) for this procedure to be consistent with RUC standards of procedures performed in the outpatient setting	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
51720	TREATMENT OF BLADDER LESION	1 96	1.50	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to evidence that incorrect assumptions were made in the previous valuation of the service. The RUC reviewed the survey data collected from the specialty society and felt that 12 minutes more adequately reflected the intra-service time for this procedure This value was between the survey median intraservice time of 17 minutes and the 25th percentile of 10 minutes. In addition, the RUC reviewed each input and made a number of changes to standardize the pre-service times. The RUC agreed that the survey median work RVU value, 1 50 Work RVUs, which accurately reflects the work associated with the procedure The RUC also agreed that the specialty society needed to ask CPT to make an editorial change in the current code descriptor which should read "retention" not detention time.	☐	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
51798	US URINE CAPACITY MEASURE	0.00	0.38	AUA commented that it requests that RUC's original recommendation for this code be reaffirmed, 0.38 RVUs	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to evidence that incorrect assumptions were made in the previous valuation of the service. The RUC would like to reaffirm its previous recommendation on this procedure. The RUC recommends the previously approved times and work RVU, 0.38 work RVUs, for this procedure	☑	1

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
52000	CYSTOSCOPY	2.01	2.23	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the technology and that there is evidence that incorrect assumptions were made in the previous valuation of the service The RUC reviewed the survey data and agreed with the specialty society that the respondents had not considered all of the intra-service work involved in this procedure. The specialty society and the RUC agreed that in looking at the distribution of responses, that the 75th percentile time of 15 minutes was more representative of the typical clinical scenario. The RUC reviewed each input and made a number of changes to standardize the pre-service times. After these adjustments were made, the RUC felt that the 25th percentile, 2 23 work RVUs, accurately reflected the amount of work associated with this code.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
52204	CYSTOSCOPY	2.37	2 59	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to evidence that incorrect assumptions were made in the previous valuation of the service. The RUC agreed with the survey median of 25 minutes of intra service. The RUC reviewed each other input and made a number of changes to the pre-service and post-service times to more adequately reflect the work associated with these service periods The RUC reviewed the relationship between other endoscopy base codes and those same endoscopy base codes performed with a biopsy and valued the biopsy at a increment of 0 36 work RVUs which was consistent with these other codes. Therefore, the RUC recommends adding this increment to the proposed work RVU for 52000 Cystourethroscopy (Proposed work RVU=2 23) to result in a 2.59 work RVU recommendation for 52204. The RUC also recommended that the specialty society request an editorial change to the code descriptor (addition of (s) following "biopsy")	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
52601	PROSTATECTOMY (TURP)	12.35	14 00	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population With the advent and widespread use of medical therapy, the number of patients requiring TURP as initial treatment for benign prostatic hyperplasia has decreased. As a consequence those patients who do undergo TURP are undergoing this procedure much later in life when their prostate has enlarged considerably. The RUC reviewed the survey data provided by the specialty and agreed with the median surveyed times and work RVU as they accurately reflect the work and time it takes to perform this procedure. The RUC recommends a work RVU of 14 00 for 52601	☑	4
53445	INSERT URO/VES NCK SPHINCTER	14 04		CAPU commented that it is concerned at the RVUs assigned to prosthetic urology procedures described by CPT codes 54411, 54405, 54400 and 53445 as they do not accurately reflect the physician work component	CAPU requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
54400	INSERT SEMI-RIGID PROSTHESIS	8.98		CAPU commented that it is concerned at the RVUs assigned to prosthetic urology procedures described by CPT codes 54411, 54405, 54400 and 53445 as they do not accurately reflect the physician work component	CAPU requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
54405	INSERT MULTI-COMP PENIS PROS	13 41		CAPU commented that it is concerned at the RVUs assigned to prosthetic urology procedures described by CPT codes 54411, 54405, 54400 and 53445 as they do not accurately reflect the physician work component	CAPU requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
54411	REMOV/REPLC PENIS PROS, COMP	15.98		CAPU commented that it is concerned at the RVUs assigned to prosthetic urology procedures described by CPT codes 54411, 54405, 54400 and 53445 as they do not accurately reflect the physician work component	CAPU requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
55700	BIOPSY OF PROSTATE	1.57	2.58	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the technique, evidence that technology has changed and evidence that incorrect assumptions were made in the previous valuation of the service When this code originated over 30 years ago the standard of care was to take 1-2 biopsies. The current clinical standard is to perform 12 or more biopsies. The RUC reviewed the survey data and made some modifications to the pre-service time to accurately reflect the work being performed. The RUC compared this procedure to 36556 Insertion of non-tunneled centrally inserted central venous catheter, age five years or older (Work RVU = 2 50), which had similar pre-, intra and post-service times and similar work. Therefore, the RUC selected the 25th percentile of the survey data, 2.58 work RVUs as this value appropriately places this service in rank order with similar services and type of technology.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
56631	EXTENSIVE VULVA SURGERY	16.18		ACOG commented that 56631 includes all services enumerated for 56630 (12 34 RVUs), but should also include the work for a unilateral inguinofemoral lymphadenectomy.	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
56632	EXTENSIVE VULVA SURGERY	20.26		ACOG commented that 56632 includes all services enumerated for 56630 (12.34 RVUs) but should also include the work for a bilateral inguinofemoral lymphadenectomy	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
56634	EXTENSIVE VULVA SURGERY	17 85		ACOG commented that 56634 includes all services enumerated for 56633 (16 45 RVUs), but should also include the work for a unilateral inguinofemoral lymphadenectomy	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
56637	EXTENSIVE VULVA SURGERY	21 94		ACOG commented that 56637 includes all services enumerated for 56633 (16 45 RVUs), but also should include bilateral inguinofemoral lymphadenectomy	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
56640	EXTENSIVE VULVA SURGERY	22.14		ACOG commented that 56640 includes all services enumerated for 56633 (16.45 RVUs), but also should include inguinofemoral, iliac and pelvic lymphadenectomy	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
57160	INSERT PESSARY/OTHER DEVICE	0 89	0.89	ACOG commented that as the population ages, they are being called upon to perform this procedure with increasing regularity. The types of prolapse and number of choices for pessaries makes this service more technically involved than in the past. In addition, our patients are increasingly more debilitated, requiring additional time	The RUC agreed that there was no compelling evidence that the current relative value is inappropriate as although the technology for this code has become more diverse, ie the types of prolapse and number of choices for pessaries, the work and times associated with this procedure have not changed	☐	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
57240	REPAIR BLADDER & VAGINA	6.06	10.56	ACOG commented that the work of this repairing the anterior endopelvic fascia is similar to that for repairing the posterior fascia. In comparison to the 10 56 value for that code which represents a similar amount of physician work, this code is clearly misvalued at 6.06 wRVUs	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to an anomalous relationship. The RUC recognized that the work of repairing the anterior endopelvic fascia is similar to that for repairing the posterior fascia In comparison to the 10.56 value for that code which represents a similar amount of physician work, this code is clearly misvalued at 6 06 RVUs Therefore, the RUC agreed with the 25th percentile of the survey data, 10.56 work RVUs, to adequately represent the amount of work being performed. The RUC felt that the median intra-service time was appropriate but made a number of changes to standardize the pre-service and post-service times	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
57250	REPAIR RECTUM & VAGINA	5 52	10.56	ACOG commented that code 45560 represents repair of rectocele alone, without penneorrhaphy Clearly, code 57250 represents more work than 45560. Therefore, the current value for 57250 if 5 52 wRVUs is anomalous in relationship to the RUC valued series of codes including 45560	The RUC agreed that there is compelling evidence that there is an anomalous relationship between code 45560 Repair of rectocele (Work RVU 10.56) and this procedure. The RUC agreed that this procedure represents similar work and intensity to the surveyed code, therefore the RUC recommends the 25th percentile of the surveyed data 10 56 work RVUs to adequately represent the work associated with this code as well as providing rank order within its family. The RUC felt that the median intra-service time was inappropriate and agreed with the specialty society that the intra-service time should be 60 minutes to more accurately reflect the services performed. In addition, a number of changes were made to standardize the pre-service and post-service times.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
57260	REPAIR OF VAGINA	8.26	13 50	ACOG commented that code 57260 represents the combination of an anterior and posterior repair with no overlap in the intraservice compenent of these procedures	The RUC agreed that there was compelling evidence that incorrect assumptions were made in the previous valuation of the service, as documented. The RUC felt that 75th percentile, 13 50 work RVUs adequately reflected the work associated with this service and places it in proper rank order with 57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethroele and 57250 Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy The RUC felt that accordingly the 75th percentile intra-service time, 90 minutes, was appropriate but made a number of changes to standardize the pre-service and post-service times	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
57265	EXTENSIVE REPAIR OF VAGINA	11 32	15.00	ACOG commented that there is an anomalous relationship between this code and 45560, a code valued by the RUC at the second 5-Year review. The work of 57265 includes all of the work of 45560, plus the work of the anterior repair and vaginal apex suspension	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to rank order anomalies in comparison with other obstetric and gynecology codes. The RUC compared this code with new proposed work values and times associated with 57260 Combined anteroposterior colporrhaphy (Proposed work RVU=13 50) and in order to maintain rank order approved the 75th percentile work RVU, 15.00 Work RVUs. The RUC felt that accordingly the 75th percentile intra-service time, 120 minutes, was appropriate but made a number of changes to standardize the pre-service and post-service times.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
57288	REPAIR BLADDER DEFECT	13.00	13.00	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the survey data and agreed with the specialty society that although there is new equipment and new statistical data to show who would benefit from this procedure, the learning curve for mastering this technology is currently quite steep. However, this learning curve is currently reflected in the existing work RVU associated with this code, 13.00 RVUs, which is validated by the survey median times and survey median work RVU (13.00 RVUs) . Therefore the RUC recommends to maintain the Work RVU associated with this procedure, 13.00 Work RVUs. The specialty society would like to recommend that this procedure be brought back for review in 2 years to address the potential shift in site of service and type of technology	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
57500	BIOPSY OF CERVIX	0.97	1.20	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC agreed with the compelling evidence that there was evidence that incorrect assumptions were made in the previous evaluation of the service. The RUC reviewed the survey data and adjusted the pre-service times recommended by the society to reflect that this procedure is performed more than 50 percent of the time with an evaluation and management service Therefore to take in to account the reduced pre-service times, the RUC felt that the 25th percentile, 1.20 Work RVUs adequately reflected the work associated with this procedure	☑	4
57550	REMOVAL OF RESIDUAL CERVIX	5 52		ACOG commented that this code has never been surveyed by the RUC There has been a substantial shift in practice patterns and the typical patient for these procedures has changed over the years. The calculated IWPUT for this procedure as it is currently valued is only 0 017. This is a rank order anomaly within the family of vaginal procedure codes.	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
57555	REMOVE CERVIX/REPAIR VAGINA	8.94		ACOG commented that 45560, rectocele repair was valued by the RUC at the second Five Year review. The value for this service is 10.56 is RVUs. Rectocele repair is an inherent part of this code and clearly demonstrated a rank order anomaly with 57555 at its current value of 8 94 wRVUs	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
57556	REMOVE CERVIX, REPAIR BOWEL	8.36		ACOG commented that the clinical practice of urogynecology has dramatically altered their understanding of pelvic organ prolapse and has substantially altered the surgical approached they undertake in correcting these problems There is a rank order anomaly, as currently valued, between this code and other pelvic apical repair codes recently valued by the RUC (57282 and 57283)	ACOG requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
58120	DILATION AND CURETTAGE	3.27	3 27	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure	The RUC reviewed the survey data collected by the specialty society and agreed with the specialty society that the data supported maintaining the times and work RVU associated with this procedure as the median value of the survey and the existing value for this procedure were very similar, 3 33 RVUs and 3.27 RVUs, respectively. The RUC modified the discharge day management to half a 99238 to be consistent with RUC rules about procedures performed in the outpatient setting. The RUC recommends maintaining the value of 3 27 for 58120.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
58150	TOTAL HYSTERECTOMY	15 22	15.98	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population The RUC reviewed the survey data provided by the specialty society and felt that in comparison to the reference code 58180 Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s) (Work RVU=14 30), felt that the 25th percentile of the survey data adequately reflected the work associated with this procedure. In addition, this value maintains rank order with other codes in the family including 58260 Vaginal hysterectomy, for uterus 250 grams or less (Work RVU=12 96). The RUC felt that the median intra-service time was appropriate but made a number of changes to standardize the pre-service times.	☑	4
58260	VAGINAL HYSTERECTOMY	12.96		CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	CMS requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
58720	REMOVAL OF OVARY/TUBE(S)	11.34	11 34	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The RUC reviewed the survey data provided by the workgroup and agreed that this procedure had similar intra-service times and work as compared to 58925 Ovarian cystectomy, unilateral or bilateral (Work RVU = 11.34) Therefore, the RUC recommends the 75th percentile for intra-service time of 90 minutes which is the same intra-service time for the reference code, however, the RUC agrees that the pre-service and post-service times should be maintained, 52 minutes and 30 minutes, respectively. The RUC recommends 11 34 Work RVUs for 58720	☑	2
61154	PIERCE SKULL & REMOVE CLOT	14 97	14 97	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC agrees with the specialty society recommendation of pre-, intra- and post-service times as well as level and number of post-operative visits However, the RUC recommends using the current work value in the RUC database of 14 97 as this produces an IWPUT of 0 080 which is appropriate relative to this family of codes and accurately reflects the amount of work associated with this procedure. The RUC recommends 14.97 work RVUs for 61154	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
61312	OPEN SKULL FOR DRAINAGE	24.53	27 00	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in the patient population The RUC reviewed the median surveyed times for pre-, intra-, and post and agrees that these time accurately reflect the service. Due to this increase in total time, most significantly noted in the additional 30 minutes of intra-service as the effects of contemporary anticoagulants like Plavix and higher levels of anticoagulation from Coumadin make emergent intra-operative hemostasis more technically demanding and time consuming, and the length of stay has not significantly changed, the survey data supports an increase in value for this service. The RUC recommends 27.00 for 61312	☑	1

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
61537	REMOVAL OF BRAIN TISSUE	24.96	35.00	AANS/CNS commented that reference code selected by the survey respondents was inappropriately valued when the this code was brought forward to the RUC. In addition, although the RUC recognized the greater time and intensity of 61537 in the RUC rationale comments, the 25th percentile was chosen to maintain appropriate rank order with 61538 as 61538 included electrocorticography.	The RUC began by addressing the compelling evidence for these codes The specialty society stated that the reason why these codes were brought forward was because there is an anomalous relationship between these codes being valued and other codes within the craniotomy family. The specialty society felt that 61538 involved the most amount of physician work within this family and this is not reflected in its current evaluation In addition, because 61538 was the key reference code when 61537 was reviewed by the RUC, there also exists a rank order anomaly for 61537 as well. The RUC agreed with the specialty society that there was an anomalous relationship and thereby compelling evidence. The RUC reviewed the service times for 61537 The RUC felt that the pre-service time needed to be adjusted to reflect the services being performed and to be consistent with other neurological surgery codes reviewed by the workgroup The RUC recommended and the societies agreed with the following times for pre-service – 60 minutes of pre-service evaluation time, 20 minutes of positioning time and 20 minutes of scrub, dress and wait time. The RUC accepted the specialty societies' recommended intra-service time and post-service time, 265 minutes and 45 minutes respectively, as they felt this time adequately reflects the services being performed. The RUC reviewed the specialty societies' recommended post-operative visits and	☐	1

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
					amended them to four-99231 visits, one-99232 visits and two-99213 office visits as they felt this more accurately reflected the post-operative care of the typical patient The RUC reviewed the recommended RVW for this procedure and agreed with the specialty society that 35 00 RVU, the 25th percentile, represents the amount of physician work associated with this code and produces an IWPUT of 0.098 which the workgroup and the specialty societies felt was appropriate The RUC recommends the 35 00 work RVUs for 61537.		

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
61538	REMOVAL OF BRAIN TISSUE	26.77	38 00	AANS/CNS commented that based upon the relative intra-service times of 61539 and 61540, it was expected that similar intra-service times would be seen between 61537 and 61538. The intra-service intensity of 61537 and 61538 should be greater than that seen in 61539 and 61540. However, the current value of 61537 results in an inappropriately lower intensity value similar to that of 61539 and 61540	The RUC began by addressing the compelling evidence for these codes The specialty society stated that the reason why these codes were brought forward was because there is an anomalous relationship between these codes being valued and other codes within the craniotomy family. The specialty society felt that 61538 involved the most amount of physician work within this family and this is not reflected in its current evaluation. In addition, because 61538 was the key reference code when 61537 was reviewed by the RUC, there also exists a rank order anomaly for 61537 as well The RUC agreed with the specialty society that there was an anomalous relationship and thereby compelling evidence. The RUC reviewed the service times for 61538 The RUC felt that the pre-service time needed to be adjusted to reflect the services being performed and to be consistent with other neurological surgery codes reviewed by the workgroup. The RUC recommended and the societies agreed with the following times for pre-service – 60 minutes of pre-service evaluation time, 20 minutes of positioning time and 20 minutes of scrub, dress and wait time. The RUC accepted the specialty societies' recommended intra-service time and post-service time, 330 minutes and 45 minutes respectively, as they felt this time adequately reflects the services being performed The RUC maintained the specialty societies' recommended post-operative visits as the	☐	1

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
					workgroup felt this accurately reflected the post-operative care of the typical patient. The RUC reviewed the recommended RVW for this procedure and agreed with the specialty society that 38 00 RVU, the 25th percentile, represents the amount of physician work associated with this code and produces an IWPUT of 0 087 which the workgroup and the specialty societies felt that this value places this code in rank order within its family. The RUC recommends the 38 00 work RVUs for 61538.		

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
61697	BRAIN ANEURYSM REPR, COMPLX	50.44	57.31	AANS/CNS commented that the initiation of this treatment and the resultant postoperative hospital stay has substantially changed in the past decade In addition there exists a rank order anomaly which has valued craniotomy for treatment of an anterior circulation aneurysm more than that of the posterior circulation, despite the greater complexity and risk of treating the less common posterior circulation aneurysms.	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in technique, knowledge/technology and length of hospital stay. The RUC reviewed the survey data for this procedure and recommends the median intra-service time of 300 minutes However, the RUC reviewed each input and made a number of changes to standardize the pre-service and post-service times and to adjust the level and number of post-operative visits as the RUC felt this was more reflective of the service. The RUC backed out the work associated with these changes from the median work RVU which results in 57.31 Work RVUs for this procedure.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
61698	BRAIN ANEURYSM REPR, COMPLX	48.34	64 03	AANS/CNS commented that this service had changed significantly in the initiation of treatment and the resultant postoperative hospital stay over the past decades	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in technique, knowledge/technology and length of hospital stay The RUC reviewed the survey data for this procedure and recommends the median intra-service time of 360 minutes However, the RUC reviewed each input and made a number of changes to standardize the pre-service and post-service times and to adjust the level and number of post-operative visits as the RUC felt this was more reflective of the service. The RUC backed out the work associated with these changes from the median work RVU which results in 64 03 Work RVUs for this procedure.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
61700	BRAIN ANEURYSM REPR, SIMPLE	50 44	46 01	AANS/CNS commented that this service had changed significantly in the initiation of treatment and the resultant postoperative hospital stay over the past decades	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in technique, knowledge/technology and length of hospital stay. The RUC reviewed the survey data for this procedure and recommends the median intra-service time of 240 minutes However, the RUC reviewed each input and made a number of changes to standardize the pre-service and post-service times and to adjust the level and number of post-operative visits as the RUC felt this was more reflective of the service. The RUC backed out the work associated with these changes from the median work RVU which results in 46.01 Work RVUs for this procedure	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
61702	INNER SKULL VESSEL SURGERY	48 34	54 28	AANS/CNS commented that this service had changed significantly in the initiation of treatment and the resultant postoperative hospital stay over the past decades	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in technique, knowledge/technology and length of hospital stay. The RUC reviewed the survey data for this procedure and recommends the median intra-service time of 280 minutes. However, the RUC reviewed each input and made a number of changes to standardize the pre-service and post-service times and to adjust the level and number of post-operative visits as the RUC felt this was more reflective of the service. The RUC backed out the work associated with these changes from the median work RVU which results in 54.28 Work RVUs for this procedure.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
62350	IMPLANT SPINAL CANAL CATH	6.86		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero. In addition, since the Harvard Study, there has been many changes in the physician work to provide these services· technology has advanced, new techniques have been developed and the patient population has changed.	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
62351	IMPLANT SPINAL CANAL CATH	9.99		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero. In addition, since the Harvard Study, there has been many changes in the physician work to provide these services technology has advanced, new techniques have been developed and the patient population has changed	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
62355	REMOVE SPINAL CANAL CATHETER	5.44		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero In addition, since the Harvard Study, there has been many changes in the physician work to provide these services. technology has advanced, new techniques have been developed and the patient population has changed.	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
62360	INSERT SPINE INFUSION DEVICE	2.62		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero In addition, since the Harvard Study, there has been many changes in the physician work to provide these services: technology has advanced, new techniques have been developed and the patient population has changed	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
62361	IMPLANT SPINE INFUSION PUMP	5 41		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero. In addition, since the Harvard Study, there has been many changes in the physician work to provide these services technology has advanced, new techniques have been developed and the patient population has changed.	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
62362	IMPLANT SPINE INFUSION PUMP	7.03		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero. In addition, since the Harvard Study, there has been many changes in the physician work to provide these services. technology has advanced, new techniques have been developed and the patient population has changed.	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
62365	REMOVE SPINE INFUSION DEVICE	5.41		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero. In addition, since the Harvard Study, there has been many changes in the physician work to provide these services technology has advanced, new techniques have been developed and the patient population has changed.	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
63047	REMOVAL OF SPINAL LAMINA	14.59	14.08	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in physician time which corresponds to an increase in intensity The RUC reviewed the survey results collected by the specialty society and recommends the pre-, intra- and post-service times as they accurately reflect the amount of time it takes to perform this procedure. Due to the associated increases and decreases in the pre-, intra- and post-service times, the RUC agreed with the specialty that 14 08 is an appropriate work RVU for this procedure as it reflects the increased intensity and shortened physician times.	☑	3

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
63048	REMOVE SPINAL LAMINA ADD-ON	3 26	3.55	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to evidence that incorrect assumptions were made in the previous evaluation of this procedure. The RUC reviewed the intra-service time for this procedure and agreed with the specialty societies' recommendation of their median value from their survey results, 45 minutes However, the RUC felt that the 25th percentile for the work RVU, 3.55 work RVUs, is appropriate as compared to the reference code 63048, Laminectomy, lumbar, each additional level (Work RVU=3 26) which has more intra-service time than the surveyed code.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
63075	NECK SPINE DISK SURGERY	19 38	18 58	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure	The RUC agreed that there was compelling evidence that the current relative value is inappropriate due to a change in length of hospital stay The RUC reviewed the survey results collected by the specialty society and recommends the pre-, intra- and post-service times as they accurately reflect the amount of time it takes to perform this procedure. Due to the associated increases and decreases in the pre-, intra- and post-service times, the RUC agreed with the specialty that 18 58 is an appropriate work RVU for this procedure as it reflects the increased intensity and shortened physician times	☑	3
63650	IMPLANT NEUROELECTRODES	6 73		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero. In addition, since the Harvard Study, there has been many changes in the physician work to provide these services technology has advanced, new techniques have been developed and the patient population has changed	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
63655	IMPLANT NEUROELECTRODES	10 27		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero In addition, since the Harvard Study, there has been many changes in the physician work to provide these services: technology has advanced, new techniques have been developed and the patient population has changed	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
63660	REVISE/REMOVE NEUROELECTRODE	6 15		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero In addition, since the Harvard Study, there has been many changes in the physician work to provide these services technology has advanced, new techniques have been developed and the patient population has changed	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
63685	INSRT/REDO SPINE N GENERATOR	7.03		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero In addition, since the Harvard Study, there has been many changes in the physician work to provide these services technology has advanced, new techniques have been developed and the patient population has changed.	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
63688	REVISE/REMOVE NEURORECEIVER	5.38		The ASA and AAPM commented that a careful review of time and intensity data for this code has revealed a number of anomalous findings including time data not consistent with current practice and intensities that are often lower than that for an office visit and in some cases less than zero. In addition, since the Harvard Study, there has been many changes in the physician work to provide these services technology has advanced, new techniques have been developed and the patient population has changed.	ASA and AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
64550	APPLY NEUROSTIMULATOR	0.18		AAPM commented that there have been many changes in the physician work required to provide these services: technology has advanced, new techniques have been developed and the patient population has changed	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64553	IMPLANT NEUROELECTRODES	2.31		AAPM commented that there have been many changes in the physician work required to provide these services technology has advanced, new techniques have been developed and the patient population has changed.	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64555	IMPLANT NEUROELECTRODES	2.27		AAPM commented that there have been many changes in the physician work required to provide these services technology has advanced, new techniques have been developed and the patient population has changed.	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
64560	IMPLANT NEUROELECTRODES	2.36		AAPM commented that there have been many changes in the physician work required to provide these services technology has advanced, new techniques have been developed and the patient population has changed	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64561	IMPLANT NEUROELECTRODES	6 73		AAPM commented that there have been many changes in the physician work required to provide these services. technology has advanced, new techniques have been developed and the patient population has changed	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64565	IMPLANT NEUROELECTRODES	1 76		AAPM commented that there have been many changes in the physician work required to provide these services: technology has advanced, new techniques have been developed and the patient population has changed.	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
64573	IMPLANT NEUROELECTRODES	7.49		AAPM commented that there have been many changes in the physician work required to provide these services: technology has advanced, new techniques have been developed and the patient population has changed.	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64575	IMPLANT NEUROELECTRODES	4 34		AAPM commented that there have been many changes in the physician work required to provide these services: technology has advanced, new techniques have been developed and the patient population has changed	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64577	IMPLANT NEUROELECTRODES	4.61		AAPM commented that there have been many changes in the physician work required to provide these services. technology has advanced, new techniques have been developed and the patient population has changed.	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
64580	IMPLANT NEUROELECTRODES	4.11		AAPM commented that there have been many changes in the physician work required to provide these services technology has advanced, new techniques have been developed and the patient population has changed	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64581	IMPLANT NEUROELECTRODES	13.48		AAPM commented that there have been many changes in the physician work required to provide these services: technology has advanced, new techniques have been developed and the patient population has changed.	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64585	REVISE/REMOVE NEUROELECTRODE	2.06		AAPM commented that there have been many changes in the physician work required to provide these services· technology has advanced, new techniques have been developed and the patient population has changed.	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	RUC Rationale	Change in Time from 2005?	Action Key
64590	INSRT/REDO PERPH N GENERATOR	2 40		AAPM commented that there have been many changes in the physician work required to provide these services technology has advanced, new techniques have been developed and the patient population has changed.	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7
64595	REVISE/REMOVE NEURORECEIVER	1.73		AAPM commented that there have been many changes in the physician work required to provide these services. technology has advanced, new techniques have been developed and the patient population has changed	AAPM requested this code be withdrawn from consideration at the 2005 Five Year Review	☐	7

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CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

		Recommended Work Relative Value
CPT Code:22520	Global Period: 010	Specialty Society RVU: **8.90**
		RUC RVU: **8.90**

CPT Descriptor: Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic (For radiological supervision and interpretation, see 76012, 76013)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old woman develops sudden, severe mid back pain after loading groceries in her car. Plain radiographs reveal an acute compression fracture of T9. Pain persists despite bed rest and narcotic analgesics for 2 weeks. Percutaneous thoracic vertebroplasty (and bone biopsy if indicated) are performed. The patient is discharged after the procedure and followed as necessary in the office through the 10-day global period. [Intraoperative fluoroscopy or CT imaging would be reported separately using the appropriate code.]

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
The patient's medical history and physical examination findings are reviewed. Physical, psychological or other contraindications to the procedure are excluded. The indications for the procedure are reviewed with the patient and appropriate counseling performed. Potential risks of the procedure are explained. Patient questions are answered. Relevant preoperative diagnostic imaging studies are reviewed. Pre-operative laboratory investigations, if indicated, are ordered and reviewed. The anesthesia provider is informed as to the requirements for the procedure and a separate anesthesia preoperative evaluation performed. The patient is examined in the holding area and any additional questions are answered. Preoperative consent is obtained and reviewed. The area of surgery is marked. A peripheral intravenous line is established. Any required pre-operative medications are administered. Appropriate pre-operative imaging studies are brought into and displayed in the operating room. Required operative materials are checked to confirm appropriateness and availability. The patient is positioned in the prone position on a radiolucent operating room table, with or without additional positioning devices to maximize fracture reduction. The appropriate operative level is checked with imaging (x-ray or fluoroscopy) and marked. While the patient undergoes aseptic skin preparation, the surgeon scrubs at the sink, and downs sterile gown and gloves. The surgical area draped in sterile manner, and the operation commences.

Description of Intra-Service Work: The operative level is confirmed under fluoroscopy. While sedation is administered by the anesthesia provider, local anesthetic is infiltrated at the incision site and into the subcutaneous tissues and periosteum. A scalpel is used to incise the skin and subcutaneous tissue. Hemostasis is maintained with electrocautery as necessary. A bone biospy trocar (typically 11 gauge) is then advanced under multiplanar fluoroscopic imaging in a posterior-oblique approach, medial to the pleura, toward the base of the T9 pedicle, penetrating periosteum and targeting the ventral third of the vertebral body in the midline. Additional CT imaging may be used to confirm trocar placement within the vertebral body in the desired position (imaging separately billable). The introducer stylet is removed from the trocar, and 3-5 mL of non-ionic radio-opaque contrast is injected through the trocar under real-time multi-planar fluoroscopic imaging. Ideally, opacification of the trabecular space of vertebral body, with secondary venous run-off into the basilo-vertebral venous plexus is observed. PMMA cement with radio-opaque additives (e.g. powdered barium tungsten) is then mixed. Once the PMMA cement has cured to the desired consistency, the cement is incrementally injected in 1 mL aliquots into the vertebral body under real-time multi-planar fluoroscopic imaging. Cement is injected until the ventral two-thirds to three-quarters of the vertebral body has been opacified by cement (typically 3 mL cement). The trocar is removed and hard copy multiplanar radiographs obtained to assess adequacy of cement filling. Real time fluoroscopy is utilized during injection to make sure that cement does not migrate into the basilo-vertebral veins or into

the ventral spinal canal. [If unilateral vertebral body filling with cement is demonstrated, the procedure is repeated from the contralateral side.] After completion of the procedure, multi-planar hard copy radiographs are taken to assess the adequacy of vertebral body cement filling, and to verify that no venous migration of cement is observed. The wound is closed and sterile dressings applied..

Description of Post-Service Work:

Hospital:

The patient is then awakened from anesthesia (if required). The patient is then placed on a transport stretcher and assessed neurologically. The patient is then taken to the recovery room. The patient undergoes a neurologic examination and the wound/dressing is assessed in the recovery room. Recovery room care and medications are reviewed with recovery room staff. The surgeon speaks with the family regarding the procedure. An operative report is dictated. Post-operative prescriptions are written. The patient is examined and detailed post-operative and wound care instructions are given to the patient and family prior to discharge. Questions regarding post-operative care are answered. The referring physician in contacted regarding the outcome of the procedure. Any administrative or insurance staff questions are answered.

Office

The patient is contacted the day after surgery to address questions and assess for complications. The patient is seen in follow-up examination for assessment of wound healing or any operative complications, and any medication adjustments after the procedure. Progress notes are dictated into the patient's outpatient chart. Verbal and written communication with the referring physician and physical therapist regarding the patient's progress is made. New radiographs may be obtained and reviewed as indicated.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	Charles Mick, MD; Robert Boop, MD; Chris Kaufman, MD; Robert Vogelzang, MD; Zachary Rattner, MD; Bibb Allen Jr., MD					
Specialty(s):	NASS; AANS/CNS; AAOS; SIR; ASNR; ACR					
CPT Code:	22520					
Sample Size:	1598	**Resp n:** 244		**Response:** 15.2 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.00	8.89	**8.90**	10.00	19.00
Pre-Service Evaluation Time:				**30.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		15.00	30.00	**45.00**	60.00	240.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**23.0**	99211x **0.0** 12x **0.0** 13x **1.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
2252X1	010	8.94

CPT Descriptor Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, one vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
38510	010	6.42

CPT Descriptor 1 Biopsy or excision of lymph node(s); open, deep cervical node(s)

MPC CPT Code 2	Global	Work RVU
31290	010	17.21

CPT Descriptor 2 Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region

Other Reference CPT Code	Global	Work RVU
22554	010	8.89

CPT Descriptor Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic (For radiological supervision and interpretation, see 76012, 76013)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 183 **% of respondents:** 75.0 %

TIME ESTIMATES (Median)

	CPT Code: 22520	**Key Reference CPT Code: 2252X1**
Median Pre-Service Time	60.00	60.00
Median Intra-Service Time	45.00	58.00
Median Immediate Post-service Time	30.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	36.00
Median Office Visit Time	23.0	23.00
Median Total Time	**176.00**	**197.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.62	
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.69	
Urgency of medical decision making	3.28	

Technical Skill/Physical Effort (Mean)

Technical skill required	3.61	
Physical effort required	3.22	

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	
Outcome depends on the skill and judgment of physician	3.80	
Estimated risk of malpractice suit with poor outcome	4.05	

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.34	
Intra-Service intensity/complexity	3.26	
Post-Service intensity/complexity	3.21	

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

For 22520 we recommend an RVW of 8.89, which represents no change. This procedure is very similar to kyphoplasty 252X1) which was valued by the RUC in April 2005. The RUC agreed in April that the work of these two procedures was similar. A value of 8.89 maintains the rank order in relationship to Kyphoplasty (RVW 8.94) both with the relationship with pre, intra, and post service times, and IWPUT. Our recommended RVW yields an IWPUT of .097, which is very slightey higher than the Kyphoplasty IWPUT of .093. We feel this is justified by the additional complexity involved in the Vertebroplasty procedure introduced by the risk of possible cement leakage.

Based on the 244 total responses, we recommend the median survey total pre-service time for history, evaluation, positioning, scrub, dress and waiting of 95 minutes. This is an increase compared to the current value of 30 minutes which was based upon 39 responses obtained when vertebroplasty was being developed in academic centers. The thirty minutes significantly underestimates the time required to complete the preservice activites that the elderly patients undergoing this procedure require. Vertebroplasty is typically performed in a frail and elderly population with multiple co-morbid conditions, very similar to those patients sustaining a hip fracture. Pre-service history and evaluation of 60 minutes is typical. The time required to place an older, kyphotic, often respiratory compromised patient in the prone position and assure adequate fluroscopic imaging of the compressed vertebra of 20 minutes is typical. 15 minutes of time for scrubbing, dressing and waiting is also typical. The median survey preservice time that we obtained for 22520, is very similar to the median survey time obtained for kyphoplasty (N=112) of 86 minutes. The RUC modified this time but agreed that the work of both vertebroplasty and kyphoplasty were similar. We believe the median survey times obtained by our large number of respondants and further supported by the results of the kyphoplasy survey are correct.

Based on the 244 total responses, we recommend the median survey intra-service time of 45 minutes. This represents a significant decrease compared to the current value of 80 minutes obtained when the percutaneous approach was unfamiliar to many physicians first performing the procedure. It compares well with the 58 minutes of intra time for kyphoplasty. The median survey post-service time, which we recommend as the accepted value, is 30 minutes.

Vertebroplasty is most typically performed on an outpatient basis, and we recommend one post-operative discharge management code of 99238 . We also recommend one post-discharge follow up visit within the 10 day global of 99213.

	Current Values	Median Survey Values	Difference	Kyphoplasty
Pre-service H&E	30	80	+50	45 (71)
Pre-service S&W	0	15	+15	15
Intra-service	80	45	-35	58
Immediate Post	30	30	0	20
Post-Op visits				
99231				
9232				
99233				
99238	36	36	0	36
99239				
Post-Dis visits				
99211				
99212	0	0	0	
99213	23	23	0	23
99214				
99215				
Total RUC time	199	229		197 (223)
Total RUC Time Change				+30
IWPUT	0.072	0.111		0.093

Our median survey value of 9.5 results in an IWPUT of 0.111. We believe this is too high. Using our recommended, unchanged RVW of 8.89 and our median survey times, we computed an IWPUT for 22520 of .097. This RVW of 8.89 also corresponds to our 25th percentile survey result.

We feel an IWPUT higher than the current value is justified by the additional data collected in our survey and because more work is being performed in less time but with greater intensity. In our surveys (please see above), we asked respondents to indicate the degree to which intensity and complexity has changed in the past five years using the same 11 basic categories of work complexity and intensity used for standard RUC surveys. The question was on a 1-5 scale with representing "a great deal more" and 1 representing "a great deal less" and 3 representing "no change". All 11 categories had a mean response greater than 3, indicating overall increases in complexity and intensity. Scoring particularly high were the last three questions assessing risk, skill and malpractice.

Conscious sedation is inherent to vertebroplasty when performed in an office setting. Kyphoplasy has not been valued in an office setting.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☒ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

76012 Radiological supervision and interpretation, percutaneous vertebroplasty, per vertebral body; under fluoroscopic guidance

.'ypically One Level

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	22520	10	100%	8.89.	95	45	59	229
2.	76012	XXX	NA	1.31	45	60	15	120
	TOTAL			10.20	140	105	74	349

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 10% No 90%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 100% I do not agree 0%
B. Patients requiring this service are now:
   more complex (more work) 0% less complex (less work) 0% no change 100%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 10% no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 22520

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		80.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 53.0	Staff % of Physician time 66%
Clinical Staff #2	Staff Type: RN	Intra Assist Physician Time: 80.0	Staff % of Physician time 100%
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211: 0.0	
		99212: 0.0	
		99213: 1.0	
		99214: 0.0	
		99215: 0.0	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		45.0		
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 30.0	Staff % of Physician time 66%	**Change: In Time** 23.0
Clinical Staff #2	Staff Type: RN	Intra Assist Physician Time: 45.0	Staff % of Physician time 100%	**Change: In Time** 35.0
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:** 0.5		
Number and Level of Office Visits:		**99211:** 0.0		
		99212: 0.0		
		99213: 1.0		
		99214: 0.0		
		99215: 0.0		

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:22554 Global Period: 090 Specialty Society RVU: **16.4**
RUC RVU: **16.40**

CPT Descriptor: Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old women presents with neck pain radiating to the right hand with numbness, tingling and weakness. Six weeks of non-operative treatment are unsuccessful and imaging studies identify C 5/6 spondylosis. She undergoes anterior excision of the C 5/6 disc and preparation of the end plates for arthrodesis. Postoperative hospital care and office visits are conducted as necessary through the 90 day global period. [Instrumentation, decompression and/or bone grafting would be reported separately using the appropriate code(s).]

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Locate, review, and place MRI and/or other spinal imaging studies on the view box in the operating room; Review planned incisions and procedure; Greet patient in holding area and review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Sign and mark operative site; Obtain informed consent; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of anesthesia; Following the induction of anesthesia, assist with repositioning of patient; verify/assist with padding of the patient to prevent pressure on neurovascular structures; Scrub and gown; Mark the incisions and supervise prepping/draping of the patient

Description of Intra-Service Work:
A transverse incision is made anteriorly over the level of the proposed arthrodesis. The platysma muscle is cut in line with the skin incision. The interval between the sternocleidomastoid and carotid sheath laterally and the trachea and esophagus medially is developed and the prevertebral fascia cleared from the front of the spine. The disc between the vertebrae to be fused is identified and the level confirmed by x-ray. The longus colli muscles are mobilized along their medial edges. Lateral and longitudinal self retaining traction devices are inserted. The anterior longitudinal ligament and anterior anulus are removed by sharp dissection. The disc and cartilaginous end-plates are removed by curettage. . With the disc space under distraction, the bone graft (coded separately) is inserted into the disc space. The traction is released and the graft checked for security. Any protruding parts of the graft are trimmed to avoid esophageal compression. A drain is placed in the wound as desired. The platysma muscle, subcutaneous tissue, and skin are sutured. Sterile dressings and a collar or brace are applied.

Description of Post-Service Work:
Hospital:
When anesthesia has been reversed, transfer patient to the recovery room; Write an OP note in the patient's record; examine patient, check wound(s) and patient progress, monitor for abnormal neurological findings; Sign OR forms, including pre- and postoperative diagnosis, operations performed; Discuss procedure outcome with family; Dictate postop report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company; Order and review films to check alignment of cervical spine;

CPT Code:

Write orders daily, as necessary, for medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other staff patient chart notes; Chart patient progress notes; Discuss patient progress with referring physician (verbal and written); Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions; At discharge, review post-discharge wound care, use and proper fit of collar, and ctivity limitations, including planned physical therapy; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge films, and medications; Chart patient discharge notes

Office:

Write orders for medications and follow-up films; Review post-discharge films; Examine patient - perform periodic neurological exams; Monitor wounds and remove sutures/staples; Review use and proper fit of collar with patient; Review physical therapy progress and revise orders as needed; Dictate patient progress notes for medical chart; Answer patient/family questions, insurance staff questions; Discuss patient progress with referring physician (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	Charles Mick, MD; Robert Boop, MD; Chris Kauffman, MD					
Specialty(s):	NASS; AANS/CNS; AAOS					
CPT Code:	22554					
Sample Size:	1500	**Resp n:** 197		**Response:** 13.1 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		18.00	19.50	**16.40**	22.80	36.00
re-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**20.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		20.00	70.00	**90.00**	120.00	360 00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**30.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**30.0**	99231x **0.0** 99232x **1.0** 99233x **0.0**				
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**69.0**	99211x **0.0** 12x **0.0** 13x **3.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3050	090	20.75

CPT Descriptor Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
65750	090	14.98

CPT Descriptor 1 Keratoplasty (corneal transplant); penetrating (in aphakia)

MPC CPT Code 2	Global	Work RVU
22595	090	19.36

CPT Descriptor 2 Arthrodesis, posterior technique, atlas-axis (C1-C2)

Other Reference CPT Code	Global	Work RVU
22554	090	18.59

CPT Descriptor Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 197 **% of respondents:** 100.0 %

TIME ESTIMATES (Median)

	CPT Code: 22554	**Key Reference CPT Code: 63050**
Median Pre-Service Time	95.00	95.00
Median Intra-Service Time	90.00	150.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	69.0	61.00
Median Total Time	**350.00**	**440.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.82	3.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	4.03
Urgency of medical decision making	3.39	3.58

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	4.03
Physical effort required	3.49	3.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.97	3.99
Outcome depends on the skill and judgment of physician	4.10	4.18
Estimated risk of malpractice suit with poor outcome	4.59	4.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.64	3.72
Intra-Service intensity/complexity	3.53	3.75
Post-Service intensity/complexity	3.36	3.61

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We recommend a RVW of 16.4, which represents a total decrease of 2.19 from the current RVW of 18.59.

We obtained this value by utilizing building block methodology (see attached tables). Our 197 respondents indicated a median RVW of 20.00. We modified this by either subtracting or adding the differences between each specific time category by comparing the current values from the RUC database to the median survey responses.

	Current Values	Survey Values	CPT Code: Difference
Pre-service H&E	60	80	+20
Pre-service S&P	15	15	0
Intra-service	120	90	-30
mmediate Post	20	30	+10
Post-Op visits			
99231	19	0	-19
99232	30	30	0
99233			
99238	36	36	0
99239			
Post-Dis visits			
99211			
99212			
99213	92	69	-23
99214			
99215			
TOTAL RUC TIME	392	350	
Total RUC Time Change			-42
IWPUT	0.092	0.148	

Our median survey value of 20 results in an IWPUT of 0.148 which we thought was too high. Our 25% was 19.5 (IWPUT= 0.143) which we also thought was too high. Using our recommended RVW of 16.4 and our median survey times, , we computed an IWPUT for 22554 of 0.106.

We believe a higher IWPUT is justified by the additional data collected in our survey and because the work is being performed in less time but at greater intensity. Our median intraservice time indicates that we now complete this omponent of work in 90 minutes compared to the 120 minutes in the current RUC database. In our surveys (please see bove), we asked respondents to indicate the degree to which intensity and complexity has changed in the past five years using the same 11 basic categories of work complexity and intensity used for standard RUC surveys. The question was on a 1-5 scale with 5 representing "a great deal more" and 1 representing "a great deal less" and 3 representing "no change". All 11 categories had a mean response greater than 3, indicating overall increases in complexity and intensity. Scoring particularly high were the last three questions assessing risk, skill and malpractice.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☒ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☒ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Typically One Level

	CPT	global	multi	RVW	Pre	Intra	Post	Total	
1.	22554	90	100%	16.40*	95	90	165	350	*proposed RVW
2.	63075	90	50%	9.69		90		90	
3.	22845	ZZZ	100%	11.96	0	90	0	90	
4.	20936	XXX	100%	0.00	0	0	0	0	
				38.05	95	270	165	530	

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 50% No 50%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 40% less complex (less work) 0% no change 60%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 40% no change 60%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 22554

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:22612 Global Period: 090 Specialty Society RVU: **22.58**
RUC RVU: **22.00**

CPT Descriptor: Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old-male has a one-year history of progressive low back pain unresponsive to conservative treatment. Imaging studies identify L5/S1 spondylolisthesis. He undergoes posterolateral fusion of L5 to S1. Post operative hospital care and office visits are conducted as necessary through the 90-day global period. [Instrumentation and/or bone preparation or harvesting would be reported separately using the appropriate code(s).]

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Locate, review, and place MRI and/or other spinal imaging studies on the view box in the operating room; Review planned incisions and procedure; Greet patient in holding area and review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Sign and mark operative site; Obtain informed consent; Verify that all necessary surgical instruments, supplies, and devices are available in the perative suite; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of anesthesia; Following the induction of anesthesia, assist with repositioning of patient; verify/assist with padding of the patient to prevent pressure on neurovascular structures; Scrub and gown; Mark the incisions and supervise prepping/draping of the patient

Description of Intra-Service Work:
A mid-line incision is made over the spinous processes of the vertebrae to be fused plus one or more segments above and below in order to provide for adequate retraction and safe exposure of the bone to be prepared. The paraspinal muscles and fascia are stripped from the lateral surfaces of the spinous processes and the posterior surfaces of the laminae by subperiosteal dissection. The capsules of the facet joints to be fused are removed and cartilage removed from the joint surfaces. The muscle attachments and periosteum are stripped from the posterior cortices of the transverse processes of the vertebra to be fused and from the lateral edge of the pars interarticularis and pedicles posterior to the transverse process. (Instrumentation and/or bone harvesting, if used, are coordinated at this point, and are coded separately.) The bone graft material is applied over the prepared surfaces of the bone (decorticated transverse processes and lateral facets) and in the intervals between. The muscles and fascia are sutured. One or more drains are placed through separate stab wounds if desired. The subcutaneous tissue and skin are closed in layers. Sterile dressings are applied. (Alternatively, the posterolateral fusion can be accomplished through muscle splitting incisions on each side of the spine with exposure of the transverse process and facet joints through two posterolateral approaches.)

Description of Post-Service Work:
Hospital:
Turn patient into the supine position; When anesthesia is reversed, transfer to recovery room; Write an OP note in the patient's record; Examine patient, check wound(s) and patient progress, monitor for abnormal neurological findings; gn OR forms, including pre- and postoperative diagnosis, operations performed; Discuss procedure outcome with family; Dictate postop report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company; Order and review films to check alignment of lumbar spine; Write orders daily, as necessary, for medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other staff patient chart notes; Chart patient progress notes;

Discuss patient progress with referring physician (verbal and written); Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions; At discharge, review post-discharge wound care, use and proper fit of brace, and activity limitations, including planned physical therapy; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge films, and medications; Chart patient discharge notes

Office:
Write orders for medications and follow-up films; Review post-discharge films; Examine patient - perform periodic neurological exams; Monitor wounds and remove sutures/staples; Review use and proper fit of brace with patient; Review physical therapy progress and revise orders as needed; Dictate patient progress notes for medical chart; Answer patient/family questions, insurance staff questions; Discuss patient progress with referring physician (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	Charles Mick, MD; Robert Boop, MD; Chris Kauffman, MD					
Specialty(s):	NASS; AANS/CNS; AAOS					
CPT Code:	22612					
Sample Size:	1500	**Resp n:** 202		**Response:** 13.4 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		17.00	22.00	**23.00**	25.00	40.00
Pre-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**20.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		30.00	120.00	**150.00**	180.00	460.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**30.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**79.0**	99231x **1.0** 99232x **2.0** 99233x **0.0**				
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**				
Office time/visit(s):	**69.0**	99211x **0.0** 12x **0.0** 13x **3.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
22595	090	23.36

CPT Descriptor Arthrodesis, posterior technique, atlas-axis (C1-C2)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
22554	090	18.59

CPT Descriptor 1 Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression); cervical below C2

MPC CPT Code 2	Global	Work RVU
33533	090	29.96

CPT Descriptor 2 Coronary artery bypass, using arterial graft(s); single arterial graft

Other Reference CPT Code	Global	Work RVU
22612	090	20.97

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 202 **% of respondents:** 100.0 %

TIME ESTIMATES (Median)

	CPT Code: 22612	**Key Reference CPT Code: 22595**
Median Pre-Service Time	95.00	90.00
Median Intra-Service Time	150.00	150.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	79.0	94.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	69.0	92.00
Median Total Time	**459.00**	**492.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.95	3.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.01	4.06
Urgency of medical decision making	3.27	3.61
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.83	4.15
Physical effort required	3.85	3.77
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.84	4.10
Outcome depends on the skill and judgment of physician	4.08	4.21
Estimated risk of malpractice suit with poor outcome	4.44	4.56

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.76	3.74
Intra-Service intensity/complexity	3.60	3.85
Post-Service intensity/complexity	3.53	3.82

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
We recommend a RVW of 22.58, which represents a total increase of 1.61 from the current RVW of 20.97.

We obtained this value by utilizing building block methodology (see attached tables). Our 197 respondents indicated a median RVW of 23.00. We modified this by either subtracting or adding the differences between each specific time category by comparing the current values from the RUC database to the median survey responses.

	Current Values	Survey Values	CPT Code: Difference
Pre-service H&E	75	80	+5
Pre-service S&P	15	15	0
Intra-service	150	150	0
mmediate Post	15	30	+15
Post-Op visits			
99231	87	19	-68
99232	0	60	+60
99233			
99238	36	36	0
99239			
Post-Dis visits			
99211			
99212			
99213	92	69	-23
99214			
99215			
Total RUC Time Change			-11
TOTAL RUC TIME	470	459	
IWPUT	0.080	0.099	

We feel a higher IWPUT is justified by the greater intensity and complexity, of this procedure. In our surveys (please see above), we asked respondents to indicate the degree to which intensity and complexity has changed in the past five years using the same 11 basic categories of work complexity and intensity used for standard RUC surveys. The question was on a 1-5 scale with 5 representing "a great deal more" and 1 representing "a great deal less" and 3 representing "no change". All 11 categories had a mean response greater than 3, indicating overall increases in complexity and intensity. Scoring particularly high were the last three questions assessing risk, skill and malpractice.

The recommended RVU falls midway between the 25% and median survey value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☒ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

22612 may be used alone or with a variety of other codes. Several scenarios are listed below

Typically One Level Fusion with instrumentation and bone graft

	CPT	global	multi	RVW	Pre	Intra	Post	Total	
1.	22612	90	100%	22.58*	95	150	214	459	*proposed RVW
2.	22840	ZZZ	100%	12.52		105		105	
3.	20937	ZZZ	100%	2.79	0	40	0	40	
	TOTAL			37.89	95	295	214	604	

Typically One Level Fusion with decompression

	CPT	global	multi	RVW	Pre	Intra	Post	Total	
1.	22612	90	100%	22.58*	95	150	214	459	*proposed RVW
2.	63047	090	50%	7.29		120		120	
3.	TOTAL			29.87	95	270	214	579	

Typically Two Level Fusion with instrumentation and bone graft

	CPT	global	multi	RVW	Pre	Intra	Post	Total	
1.	22612	90	100%	22.58*	95	150	214	459	*proposed RVW
2.	22614	ZZZ	100%	6.43		40		40	
3.	22840	ZZZ	100%	12.52		105		105	
4.	20937	ZZZ	100%	2.79	0	40	0	40	
	TOTAL			44.32	95	295	214	644	

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 20% No 80%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 50% less complex (less work) 0% no change 50%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 22612

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:22840 Global Period: ZZZ Specialty Society RVU: **12.52**

RUC RVU: **12.52**

CPT Descriptor: Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old woman falls, sustaining a posteriorly-displaced Type II odontoid fracture without spinal cord injury. CT imaging shows adequate pars interarticularis diameter with normal vertebral artery anatomy through the atlanto-axial region. Following a posterior cervical arthrodesis, transarticular screw placement is performed. [Note that this is an add-on code. When performing this survey, please consider only the ADDITIONAL work of the posterior screw fixation. The primary procedure is separately reportable.]

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Fluoroscopy is utilized to assess the alignment of C1 and C2. A separate incision is made caudally for the entry point of the trocar to insert the C1-2 transarticular screw. (If computer-assisted neuronavigation is used, report separately) The angle is checked with fluoroscopy with the starting point at the inferior portion of the C2 facet and the angle such that the tip of the screw will end at the C1 arch on lateral fluoroscopy. The obturator is removed from the trocar and a hole is slowly drilled with fluoroscopic imaging in multiple projections to the appropriate depth . Either an appropriate length cannulated screw is placed over the drill bit or the drill bit is removed and a screw is placed across the C1-2 joint again under fluoroscopic guidance. The procedure is then repeated on the opposite side. A C1-2 arthrodesis is then performed (reported separately).

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	Charles Mick, MD; Robert Boop, MD; Chris Kauffman, MD					
Specialty(s):	NASS; AANS/CNS; AAOS					
CPT Code:	22840					
Sample Size:	0	**Resp n:** 0		**Response:** 0.0 %		
Sample Type:						
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:						
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:			**0.00**			

CPT Code:

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
.2842	ZZZ	12.56

CPT Descriptor Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
35600	ZZZ	4.94

CPT Descriptor 1 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
22840	ZZZ	12.52

CPT Descriptor Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)

	CPT Code: 22840	**Key Reference CPT Code: 22842**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	0.00	105.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**0.00**	**105.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.90	
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	
Urgency of medical decision making	3.25	

Technical Skill/Physical Effort (Mean)

Technical skill required	3.97	
Physical effort required	3.91	

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.88	
Outcome depends on the skill and judgment of physician	4.04	
Estimated risk of malpractice suit with poor outcome	4.52	

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.73	
Intra-Service intensity/complexity	3.73	
Post-Service intensity/complexity	3.52	

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our survey respondents indicated a median intra-service time of 60 minutes which is equal to the current intra-service times in the RUC database. Although our respondants felt the intensity and complexity of the procedure had increased and median survey RVW was 15, we do not recommend a change in the RVW for 22840. We recommend maintaining the current value of 12.52. The IWPUT of 0.21 remains high for this technically demanding and unforgiving procedure.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

22840 is used with a variey of spinal fusion procedures

Typically One Level Fusion with instrumentation and bone graft

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	22612	90	100%	22.58	95	150	214	459
2.	22840	ZZZ	100%	12.52		105		105
3.	20937	ZZZ	100%	2.79	0	40	0	40
	TOTAL			37.89	95	295	214	604

Typically Two Level Fusion with instrumentation and bone graft

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	22612	90	100%	22.58	95	150	214	459
2.	22614	ZZZ	100%	6.43		40		40
3.	22840	ZZZ	100%	12.52		105		105
4.	20937	ZZZ	100%	2.79	0	40	0	40
	TOTAL			44.32	95	295	214	644

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 50% No 50%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 60% I do not agree 40%
B. Patients requiring this service are now:
   more complex (more work) 40% less complex (less work) 0% no change 60%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 22840

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:50590 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **10.34**
RUC RVU: **9.08**

CPT Descriptor: Lithotripsy, extracorporeal shock wave

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old man has a 1.5 cm radio-opaque stone in the left renal pelvis which is symptomatic.
All physician work from the day prior to surgery and for 90 days postoperative is included.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 31%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Pre-Service Work- Day before surgery:

- Review pre-op lab results
- Review medical record
- Write pre-op orders (to be emailed or faxed to hospital)
- Obtain and review all imaging studies

're-Service work- Day of surgery:

- Change into scrub clothes.
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns (ie., jet ventilator)
- Transfer patient to lithotripsy table
- Take "time out" for patient identification
- Wait for anesthesiologist to administer general anesthetic
- Put on lead apron and insert ear plugs

Description of Intra-Service Work:

- Position patient into shockwave focal point
- Check cardiac rate; decide on "gated" or "ungated" treatment plan
- Check visualization of stone on monitors
- Start treatment
- Perform intermittent fluoroscopy to check on stone for movement
- As stone fragments, reposition patient multiple times to maintain shockwave focal point during treatment
- Adjust intensity of shockwave, gradually increasing intensity levels during treatment
- Conclude treatment when either the maximum allowable number of shocks have been delivered or the stone has been fragmented, whichever occurs first
- Place Foley catheter if indicated
- Move patient off shockwave generator

escription of Post-Service Work:
'ost-op Same day work through discharge from recovery :

- Wait for anesthesiologist to awaken patient
- Remove Foley catheter if indicated
- Assist in transfer of patient from lithotripsy table to post-op stretcher

- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Review recovery area care and medications with staff
- Meet with family and discuss the procedure, expected outcome, planned post operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Conduct post-op pain assessment
- Write any further necessary orders, check pain status
- Dictate operative report
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)

Post-op Same day work after discharge from recovery:

- Examine patient, and check progress
- Conduct post-op pain assessment
- Write note in progress note section of medical record
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care with patient and family
- Dictate detailed hospital discharge summary
-

Post-op Office work- After discharge from hospital:

- Examine patient and check for ecchymosis, check vital signs
- Conduct post-op pain assessment
- Check urinalysis
- Check serum creatinine
- Check KUB X-ray if indicated
- Check renal ultrasound if indicated
- Answer questions from patient and family
- Write necessary prescriptions
- Schedule next office visit
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Thomas P. Cooper, M.D.					
Specialty(s):	Urology					
CPT Code:	50590					
Sample Size:	588	**Resp n:** 52		**Response:** 8.8 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		8.00	10.00	**9.08**	12.00	21.00
Pre-Service Evaluation Time:				**35.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**13.0**		
Intra-Service Time:		25.00	45.00	**60.00**	60.00	100.00
Post-Service	**Total Min****	**CPT code / # of visits**				

CPT Code:

Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**18.0**	99238x **0.50** 99239x **0.00**
Office time/visit(s):	**61.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
53850	090	9.43

CPT Descriptor Transurethral destruction of prostate tissue; by microwave thermotherapy

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
44950	090	9.99

CPT Descriptor 1 Appendectomy

MPC CPT Code 2	Global	Work RVU
28299	090	10.56

CPT Descriptor 2 Correction, hallux valgus (bunion), with or without sesamoidectomy; by double osteotomy

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 32.6 %

TIME ESTIMATES (Median)

	CPT Code: 50590	**Key Reference CPT Code: 53850**
Median Pre-Service Time	63.00	60.00
Median Intra-Service Time	60.00	90.00
Median Immediate Post-service Time	30.00	45.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	61.0	46.00
Median Total Time	**232.00**	**241.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.12	2.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	3.18
Urgency of medical decision making	3.24	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	2.75	2.44
Physical effort required	2.44	2.29

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.88
Outcome depends on the skill and judgment of physician	3.06	2.65
Estimated risk of malpractice suit with poor outcome	2.59	2.65

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.18	3.12
Intra-Service intensity/complexity	3.12	2.94
Post-Service intensity/complexity	3.00	3.06

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our RUC recommendations are based on survey responses from urologists located across the country, including rologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the survey data associated with each code and determine the final RUC recommendation.

The expert panel reviewed the intraservice time and felt it was too low. The new third generation lithotripsy equipment takes longer as the frequency wave is lower, typically taking at least 60 minutes with the typical lithotripsy center treating five patients per day.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 40% No 60%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 43% I do not agree 57%
B. Patients requiring this service are now:
   more complex (more work) 67% less complex (less work) 5% no change 29%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 33% no change 67%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 50590

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		80.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 52.0	Staff % of Physician time 65%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		60.0		
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 39.0	Staff % of Physician time 65%	**Change: In Time** 13.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:** 0.5		
Number and Level of Office Visits:		**99211:**		
		99212: 1.0		
		99213: 2.0		
		99214:		
		99215:		

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:51720 Global Period: 000 Specialty Society RVU: **1.96**
RUC RVU: **1.50**

CPT Descriptor: Bladder instillation of anticarcinogenic agent (including detention time)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old man is 4 weeks post-op TUR of a non-invasive transitional carcinoma of the bladder. He is a candidate for intravesical BCG therapy. BCG is reconstituted and placed in the bladder per BCG protocol. Possible side effects of the BCG treatment are carefully reviewed with the patient.

(NOTE: If an Evaluation and Management service is performed on the same day it is separately billable with a "-25" modifier.)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Pre-Service work day prior to surgery:

- Check to be sure the chemotherapeutic drug is available (BCG most common, less commonly used are Thiotepa, Interferon and Mitomycin)
- Check schedule for following day
- Check with scheduling staff to see if patient was notified, as drug has been ordered
- Review laboratory studies (e.g. CBC if Thiotepa)

Pre-Service work- Day of surgery:

- Review procedure, post-procedure recovery with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Review voiding after BCG instilled
- Urinalysis result is reviewed, must be infection free
- OSHA guidelines must be followed when the drug is mixed and prepared

Description of Intra-Service Work:

- The patient is placed supine on the exam table
- Genitalia are prepped
- Local anesthetic is instilled into the urethra
- A 16 French straight catheter is placed
- OSHA guidelines must be followed
- Any residual urine is drained
- The drug (most commonly BCG) is allowed to flow from a syringe by gravity slowly into the bladder
- The catheter is removed
- All items are carefully disposed of in a zip-lock bag per OSHA guidelines and then placed into a special chemotherapy waste container.

Description of Post-Service Work:
Description of Post-Service Work and
Post-op Same day work through discharge from recovery

- Assist patient off of exam table

- Carefully record drug lot number in medical record
- Discuss the planned retention time (2 hours for BCG)
- Meet with patient and family and discuss the immediate expected symptoms and signs
- Conduct post-op pain assessment
- Write orders/prescriptions
- Dictate detailed office note

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Thomas P. Cooper, M.D.					
Specialty(s):	Urology					
CPT Code:	51720					
Sample Size: 0	**Resp n:** 0	**Response:** 0.0 %				
Sample Type:						
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:						
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:			**0.00**			

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
51700	000	0.88

CPT Descriptor Bladder irrigation, simple, lavage and/or instillation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
31231	000	1.10

CPT Descriptor 1 Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)

MPC CPT Code 2	Global	Work RVU
36556	000	2.50

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU
51600	000	0.88

CPT Descriptor Injection procedure for cystography or voiding urethrocystography

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 34.0 %

TIME ESTIMATES (Median)

	CPT Code: 51720	**Key Reference CPT Code: 51700**
Median Pre-Service Time	0.00	15.00
Median Intra-Service Time	0.00	20.00
Median Immediate Post-service Time	0.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**0.00**	**45.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.07	2.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.29	2.07
Urgency of medical decision making	2.87	2.07

Technical Skill/Physical Effort (Mean)

Technical skill required	2.47	2.13
Physical effort required	2.20	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.80	2.13
Outcome depends on the skill and judgment of physician	3.07	2.27
Estimated risk of malpractice suit with poor outcome	3.40	2.13

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.60	1.73
Intra-Service intensity/complexity	2.73	1.87
Post-Service intensity/complexity	2.73	1.73

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our RUC recommendations are based on survey responses from urologists located across the country, including rologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the survey data associated with each code and determine the final RUC recommendation.

Having reviewed the data for this code, the panel felt that the current RVW of 1.96 is appropriate for the administration of a toxic chemotherapeutic agent. This code was suggested for review by CMS due to AUA's objection to it not having been included in the review of the drug administration codes by CPT as required by the MMA in 2004. Our concerns actually lay in the practice expense realm however. Therefore we believe the work value should remain the same.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 19% No 81%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 11% I do not agree 89%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 11% no change 89%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 51720

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		27.00	
Clinical Staff #1	Staff Type: RN	Intra Assist Physician Time: 6.0	Staff % of Physician time 22%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		12.0		
Clinical Staff #1	Staff Type: RN	Intra Assist Physician Time: 3.0	Staff % of Physician time 22%	**Change: In Time** 3.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

American
Urological
Association

August 2, 2005

William Rich, M.D.
Chairman, AMA Relative Value Committee
c/o American Medical Association
515 North State Street
Chicago, IL 60610

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RE: CPT code 51798 Measurement of post-voiding residual urine and / or bladder capacity by ultrasound, non-imaging

Dear Dr. Rich:

The American Urological Association is resubmitting previously RUC approved inputs for the above mentioned CPT code 51798. This code was, prior to 2003, a G code (G00050) which was transitioned out of the Zero Work pool. When it was crosswalked from a HCPCS G code and assigned a new CPT code (51798) it went through the standard RUC survey process by our society. Our data was then brought to the April 2002 RUC where it was fully vetted, including facilitation and the RUC approved RVU of 0.38 was forwarded to CMS. For reasons that were never entirely clear, CMS decided to reject the RUC recommendation.

We have subsequently been in communication with CMS regarding this issue and it was their recommendation that we resubmit our survey data and the RUC recommendation for this code to the current 5 year review process for RUC reaffirmation and forwarding to CMS. Accordingly, attached please find a copy of the April 2002 Summary RUC Recommendation, and a copy of the AUA's original Summary of Recommendation Form

Thank you for your time and consideration.

Sincerely,

James B. Regan, M.D.
Chair, AUA Health Policy Council
AUA RUC Delegate

Cc: Michael D. Bishop, Chair, Workgroup #3, 2005 Five Year Review
Roseanne Eagle, AMA Staff Liaison for Workgroup #3
William F. Gee, M.D., RUC Alternate
Nancy K. Edwards, Reimbursement Systems Manager, AUA

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AUA
Atlanta, Georgia
May 20–25, 2006

www.aua2006.org

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 51798 Tracking Number: AA1 Global Period: XXX ~~Recommended RVW: .58~~
RUC Recommended RVW: 0.38

CPT Descriptor: Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

A 70-year-old man complains of progressive decrease in force of urinary flow, urgency, frequency and nocturia times five. As a part of his urologic evaluation a residual urine volume needs to be determined. With the patient supine on the exam table a dedicated ultrasound machine is used to measure the residual urine immediately after the patient voids. The residual urine volume is measured at 655 ml, therefore the patient is asked to go to the bathroom again to try to empty more completely. He is then rescanned and the urine volume is measured at 608 mls.

Pre-service work:

- Ask patient to empty bladder completely in bathroom.
- Have the patient disrobe to allow examination of pubic area
- Position and drape patient in a supine position on exam table
- Turn on ultrasound machine, select gender appropriate mode

Description of Intra-Service Work:

- Palpate the abdominal area to identify the pubic bone
- Apply ultrasound jelly to suprapubic area
- The suprapubic area is repeatedly scanned, typically 3 to 6 times
- If the volume is high, as in the vignette, the patient is asked to void again and the procedure is repeated.
- The jelly is cleaned off of the patients abdominal area

Description of Post-Service Work:

- The machine notes the scan with the largest volume
- The bladder image is printed out along with the volume of urine in milliliters

SURVEY DATA:

Presenter(s) James B. Regan, M.D., Jeffrey A. Dann, M.D.

Specialty(s): American Urological Association

Sample Size: 100 Response Rate: (%): 30 Median RVW .58

Type of Sample: Mixed- panel, random

Explanation of sample size: **A random sample of general urologists was surveyed.**

	Low	25th %	Median	75 %	High
Survey RVW	0.25	0.38	0.58	0.76	1.5
Pre-Service Time	0	**5.00**	~~11~~	15	35
Intra-Service Time	0	**4.00**	8	10	60

KEY REFERENCE SERVICE:

CPT	Descriptor	2002 RVW	% RESP	GLOBE
76942	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**	**0.67**	**40%**	**XXX**
74430	**Cystography, minimum of three views, radiological supervision and interpretation**	**0.32**	27%	**XXX**

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

TIME ESTIMATES (Median)	**New/Revis. CPT Code: 51798**	**Key Reference CPT Code: 76942**
Median Pre-Time (SAME DAY EVAL)	5	
Median Intra-Time	4	
Median Immediate Post-service Time	N/A	N/A
Median of Aggregate Critical Care Times	N/A	N/A
Median of Aggregate Other Hospital Visit Times	N/A	N/A
Median Discharge Day Management Time	N/A	N/A
Median of Aggregate Office Visit Times	N/A	N/A

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgement (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	**2.44**	**2.78**
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	**2.33**	**2.5**
Urgency of medical decision making	**2.78**	**2.67**

Technical Skill/Physical Effort (Mean)

Technical skill required	**2.44**	**2.94**

Physical effort required	2.11	2.61

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.67	2.39
Outcome depends on the skill and judgement of physician	2.61	2.61
Estimated risk of malpractice suit with poor outcome	1.72	2.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.11
Intra-Service intensity/complexity	1.89	2.11
Post-Service intensity/complexity	2.11	2.44

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation:
Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the data associated with each code and determine the final RUC recommendations. In the survey instrument a question was added asking the respondents to tell us what percentage of the time the Urologist performed this procedure. The response indicated that the physician performed the scan 75% of the time, (median).

FREQUENCY INFORMATION

How was this service previously reported: The CMS code of G0050 has been used in the past to identify this procedure

(if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)

How often do physicians in your specialty perform this service? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: **American Urological Association** **XXX Commonly** _____Sometimes _____Rarely

For your specialty, estimate the number of times this service might be provided nationally in a one-year period? If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty: **American Urological Association** Frequency: **625,000 +**

For your specialty, estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? If this is a recommendation from multiple specialties please estimate frequency for each specialty.

Specialty: **American Urological Association** Frequency: **625,097**

Do many physicians perform this service across the United States? _**XXX**____**Yes** _____No

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AMA/Specialty Society RVS Update Committee
Summary of Recommendations

April 2002

Measurement of Post-Voiding Residual Urine/Bladder Capacity by Ultrasound

Code 51798 represents a new code to CPT as a transition from a G code. Code G00050 *Measurement of post voiding residual urine and/or bladder capacity by ultrasound* (Work RVU=0.00) was eliminated to signify that it is no longer associated with imaging. Code 51798 was then surveyed by urology and found that it typically is preformed by a urologist although no physician work was assigned to this code by CMS. Based on the median of their survey results, the specialty requested, a work relative value of 0.58. The RUC reviewed the specialty's request and noted that the most appropriate reference code was code 76857 *Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; limited or follow-up (eg, for follicles)* (Work RVU=0.38) rather than code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (Work RVU=0.67). Based on the specialty society's 25th percentile survey results and the similarities in work of code 76857 and 51798, **the RUC recommends a relative work value of 0.38, and physician time equal to the specialty society's surveyed 25th percentile.**

Practice Expense
The RUC reviewed in great detail the practice expense inputs in both the facility and non-facility settings for code 51798, and agreed to lower the clinical labor time for the codes since much of the work is performed by the physician. The RUC recommends 30 minutes of clinical labor time in the office and 13 minutes in the facility setting. The RUC also recommends some basic medical supplies and equipment in the office setting, as shown in the practice expense summary form attached to the recommendation for this service.

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

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
• 51798	AA1	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	XXX	0.38
G 00050		~~Measurement of post-voiding residual urine and/or bladder capacity by ultrasound~~	XXX	N/A

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

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:52000 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **2.72**
RUC RVU: **2.23**

CPT Descriptor: Cystourethroscopy (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old man with a 50 pack-year history of cigarette smoking has had gross hematuria for the past year. Cystourethroscopy is explained to the patient, and then performed to evaluate the bladder. The findings are discussed with the patient.
(NOTE: If an Evaluation and Management service is performed on the same day it is separately billable with a "-25" modifier.)

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 10%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Pre-Service Work – Day prior to procedure

- Check video equipment
- Check schedule for following day
- Be sure necessary instruments and personnel will be available
  Check with scheduling staff to see if patient was notified
- Review laboratory studies
- Be sure necessary imaging studies are available for review at time of planned procedure

Pre-Service work- Day of surgery:

- Change into scrub clothes
- Discuss procedure with anesthesiologist if appropriate
- Review surgical procedure, post-op recovery with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Evaluate patient need for antibiotics
- Take "time out" for patient identification
- Position patient on cystoscopy table
- Prep and drape patient

Description of Intra-Service Work:

- Inject local anesthetic jelly into the urethra, apply penile clamp
- Assemble endoscopic equipment, connect video system, apply defogger to lenses & video source
- Connect irrigation source
- Connect light source and white balance
- Insert endoscope into urethra
- Inspect external meatus and fossa navicularis
- Inspect urethra (pendulous and bulbar in male)
  Inspect external urinary sphincter
- Inspect prostatic urethra including presence/absence of hypertrophy, veru montanium, prostatic utricle, lateral lobes
- Assess the bladder neck (median bar, median lobe)
- Inspect trigone

- Identify the ureteral orifices (size, location)
- Check for efflux of urine from each ureter
- Inspect the bladder mucosa (trabeculation, cellules, diverticuli, lesions, stones)
- Assess bladder capacity, compliance and sensation
- Retroflex the scope if flexible (or if using a rigid scope change lenses) to inspect the dome of the bladder with suprapubic manual compression
- Drain bladder
- Disconnect video equipment and light source
- Remove endoscope

Description of Post-Service Work:
Description of Post-Service Work and
Post-op Same day work through discharge from recovery

- Assist in transfer of patient from cystoscopy table
- Assist in transfer of patient to recovery area
- Conduct post-op pain assessment
- Write post-op orders/prescriptions
- Discuss procedure and findings with patient
- Call referring physician re outcome of procedure & any unusual aspects of post-op care (cardiac disease, diabetic mgmt)
- Fill out and complete bladder mapping diagram
- Dictate detailed operative narrative
- Schedule next appointment

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Thomas P. Cooper, M.D.					
Specialty(s):	Urology					
CPT Code:	52000					
Sample Size:	588	**Resp n:** 73		**Response:** 12.4 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.88	2.23	**2.23**	3.00	6.00
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**2.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		2.00	7.75	**15.00**	15.00	60.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
43239	000	2.87

CPT Descriptor Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
36556	000	2.50

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

MPC CPT Code 2	Global	Work RVU
31622	000	2.78

CPT Descriptor 2 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)

Other Reference CPT Code	Global	Work RVU
52001	000	5.44

CPT Descriptor Cystoscopy with irrigation and evacuation of multiple obstructing clots

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 26.0 %

TIME ESTIMATES (Median)	**CPT Code: 50200**	**Key Reference CPT Code: 43239**
Median Pre-Service Time	17.00	27.00
Median Intra-Service Time	15.00	34.00
Median Immediate Post-service Time	10.00	23.50
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**42.00**	**84.50**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.50	3.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
Urgency of medical decision making	2.93	2.86

Technical Skill/Physical Effort (Mean)

Technical skill required	3.29	3.21
Physical effort required	2.50	2.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.14	2.50
Outcome depends on the skill and judgment of physician	3.21	3.14
Estimated risk of malpractice suit with poor outcome	2 86	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.07	2.07
Intra-Service intensity/complexity	2.71	2.64
Post-Service intensity/complexity	2.57	2.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the survey data associated with each code and determine the final RUC recommendation.

In the past 5 years, advances in the use of video and endoscopy equipment has become more complex and the optics have improved. Therefore both the intensity and the time have increased and has allowed urologists to better visualize and document any pathology in the bladder and/or lower urinary tract.

ntra-service time discussion: Our expert panel reviewed the survey time responses. A bi-modal distribution was noted. The panel felt that many respondents had not considered all of the intra-service work involved in this procedure. The panel, in looking at the distribution of responses, believed that the 75% percentile time of 15 minutes was more representative of the typical clinical scenario. However, the expert panel did not feel the 75% percentile for physician work at 3.00 was representative of the total work involved.

Comment to CMS: In reviewing historical records, CMS/HCFA has considered 52005 to be the base for cystoscopy. In actuality, code 52000 is the true base code for cystourethroscopy.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 26% No 74%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 50% I do not agree 50%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) 50% no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 55% no change 45%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 52000

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		14.00	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 14.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		15.0		
Clinical Staff #1	Staff Type:	Intra Assist Physician Time: 15.0	Staff % of Physician time 100%	**Change: In Time** 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:52204 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **3.08**
RUC RVU: **2.59**

CPT Descriptor: Cystourethroscopy, with biopsy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old man with a history of non-invasive transitional cell carcinoma of the bladder has undergone routine surveillance cystourethroscopy last week. Red "velvety" appearing mucosa is noted on the right hemi-trigone. The patient is brought back to OR for cystoscopy with diagnostic biopsy of the lesions.

(NOTE: If an Evaluation and Management service is performed on the same day it is separately billable with a "-25" modifier.)

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 31%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Pre-Service Work – Day prior to procedure

- Check video equipment
- Check schedule for following day
- Be sure necessary instruments and personnel will be available
- Check with scheduling staff to see if patient was notified
- Review laboratory studies
- Be sure necessary imaging studies are available for review at time of planned procedure

Pre-Service Work- Day of surgery:

- Change into scrub clothes
- Review surgical procedure, post-op recovery with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Position patient on cystoscopy table
- Prep and drape patient

Description of Intra-Service Work:

- Inject local anesthetic jelly into the urethra
- Assemble endoscopic equipment, connect video system, apply defogger to lenses & video source
- Connect irrigation source
- Connect light source and white balance
- Insert endoscope into urethra
- Inspect urethra (pendulous and bulbar in male)
- Inspect external meatus and fossa navicularis
- Inspect external urinary sphincter
- Inspect prostatic urethra including presence/absence of hypertrophy, veru montanium, prostatic utricle, lateral lobes
- Assess the bladder neck (median bar, median lobe)
- Identify the ureteral orifices (size, location)
- Check for efflux of urine from each ureter
- Inspect the bladder mucosa (trabeculation, cellules, diverticuli, lesions, stones)

- Assess bladder capacity, compliance and sensation
- Retroflex the scope if flexible (or if using a rigid scope change lenses) to inspect the dome of the bladder with suprapubic manual compression
- Drain bladder
- Insert cold cup biopsy forceps
- Perform biopsy(s) of bladder lesions or suspect areas
- Disconnect light source and video equipment
- Remove biopsy forceps with specimen
- Place and label specimens on telfa
- Place and label specimens in proper container to be sent to pathology
- Reinsert optical lens into the cystoscope sheath
- Reconnect fiberoptic light source and video
- Inspect bladder for bleeding and perforation
- Remove endoscope

Description of Post-Service Work:
Description of Post-Service Work and
Post-op Same day work through discharge from recovery

- Assist in transfer of patient from cystoscopy table
- Assist in transfer of patient to recovery area
- Conduct post-op pain assessment
- Write post-op orders/prescriptions
- Discuss procedure and findings with patient
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative
- Schedule next appointment

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Thomas P. Cooper, M.D.					
Specialty(s):	Urology					
CPT Code:	52204					
Sample Size:	588	**Resp n:** 64		**Response:** 10.8 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.50	3.08	**2.59**	5.85	7.00
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**2.0**		
Pre-Service Scrub, Dress, Wait Time:				**5.0**		
Intra-Service Time:		10.00	20.00	**25.00**	30.00	60.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**12.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30);

CPT Code:
99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
52270	000	3.36

CPT Descriptor Cystourethroscopy, with internal urethrotomy; female

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
31622	000	2.78

CPT Descriptor 1 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without fluoroscopic guidance,; diagnostic, with or without cell washing (separate procedure)

MPC CPT Code 2	Global	Work RVU
52276	000	4.99

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

Other Reference CPT Code	Global	Work RVU
52001	000	5.44

CPT Descriptor Cystourethroscopy with irrigation and evacuation of multiple obstructing clots

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 32.8 %

TIME ESTIMATES (Median)

	CPT Code: 52204	**Key Reference CPT Code: 52270**
Median Pre-Service Time	17.00	45.00
Median Intra-Service Time	25.00	27.00
Median Immediate Post-service Time	12.00	13.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**54.00**	**85.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.24	2.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.14	2.90
Urgency of medical decision making	3.05	2.81

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.10
Physical effort required	2.95	2.95

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.76	2.75
Outcome depends on the skill and judgment of physician	3.19	3.19
Estimated risk of malpractice suit with poor outcome	2.90	3.10

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.95	2.95
Intra-Service intensity/complexity	3.24	3.10
Post-Service intensity/complexity	2.90	2.86

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the survey data associated with each code and determine the final RUC recommendation.

Recommended Work Value: The panel reviewed the surveyed RVW of 4.50 and felt that a more appropriate RVW was the 25th percentile of 3.08 which would help preserve rank order in this family of codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 22% No 78%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 7% I do not agree 93%
B. Patients requiring this service are now:
   more complex (more work) 71% less complex (less work) 0% no change 29%
C. The usual site-of-service has changed:
   from outpatient to inpatient 7% from inpatient to outpatient 29% no change 64%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 52204

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		30.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 20.0	Staff % of Physician time 67%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		25.0		
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time **Time** 67%	**Change: In** 3.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:52601 Global Period: 090 Specialty Society RVU: **15.50**
RUC RVU: **14.00**

CPT Descriptor: Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 83-year-old man is in urinary retention and wearing a Foley catheter. He has failed alpha blockers and 5-alpha reductase inhibitor therapy. His prostate volume was measured at 76 cubic centimeters at the time of a prostate ultrasound and biopsy several years ago. The patient elects to have a transurethral resection of the prostate.

All physician work from the day prior to surgery and for 90 days postoperative is included.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 11%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work:
Pre-service Work- Day before surgery:

- Review pre-op lab results
  Review medical record
- Write pre-op orders (to be faxed to hospital)

Pre-service work- Day of surgery:

- Change into scrub clothes
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Position patient on endoscopic table
- Verify that all necessary instruments are available
- Take "time out" for patient identification
- Wait for anesthesiologist to give the anesthetic (general or spinal)

Description of Intra-Service Work:

- The patient is placed in the dorsal-lithotomy position, the genitalia are prepped, sterile drapes are applied
- Lubricating jelly is placed in the urethra
- Assemble endoscopic equipment, connect video system, apply defogger to lenses & video source
- Connect irrigation source
- Connect light source and white balance
- Insert endoscope into urethra
- Inspect external meatus and fossa navicularis
- Inspect urethra (pendulous and bulbar in male)
- Inspect external urinary sphincter
- Inspect prostatic urethra including presence/absence of hypertrophy, veru montanium, prostatic utricle, lateral lobes
- Assess the bladder neck (median bar, median lobe)
- Inspect trigone

- Identify the ureteral orifices (size, location)
- Check for efflux of urine from each ureter
- Inspect the bladder mucosa (trabeculation, cellules, diverticuli, lesions, stones)
- Assess bladder capacity, compliance and sensation
- Retroflex the scope if flexible (or if using a rigid scope change lenses) to inspect the dome of the bladder with suprapubic manual compression
- Drain the bladder
- Disconnect video equipment and light source
- Remove endoscope
- The urethra is dilated from 18 to 30 French using multiple dilators
- An external meatomy is performed if necessary
- An optical internal urethrotomy is performed if necessary
- The 27 French resectoscope is introduced
- The obturator is removed, the bladder drained, and the working element is placed
- The power cord, camera and light source are attached, white balanced and defogger solution applied
- Irrigation solution is attached
- Inspection of the bladder is done, ureteral orifices are identified
- The median lobe is resected first
- Lateral lobe tissue is resected, bleeders are coagulated
- Anterior prostate tissue is carefully resected so as not to injure urinary sphincter
- Apical tissue is resected adjacent to the external urinary sphincter
- At periodic intervals chips and blood clots are irrigated from the bladder
- After hemostasis is adequate thorough examination of the bladder and prostatic fossa is done to check for retained prostate chips, any found are removed with the resectoscope.
- The rectosheath is removed and rollerball loupe is inserted with complete fulguration carried out throughout entire prostatic fossa
- Disconnect video equipment and light source
- Remove the resectoscope and sheath
- At the end of the procedure a lubricated catheter guide is inserted into a #22 3-way Foley catheter.
- The guide and catheter are carefully inserted into the urinary bladder
- The catheter guide is carefully removed from the urinary catheter, then catheter is inflated
- Once the effluent is clear, the catheter is placed on traction, with 30cc in the balloon placed

Description of Post-Service Work:

Post-op Same day work through discharge from recovery

- Wait for anesthesiologist to awaken patient
- Transfer patient off of operating table
- Attach irrigation to 3-way Foley catheter
- Hand irrigate Foley catheter in operating room before transfer to recovery room
- Go with patient and anesthesiologist to recovery room
- Assist in transfer of patient to recovery area bed
- Review recovery area care and medications with staff
- Meet with patient's family and discuss the procedure, expected outcome, planned post-operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Conduct post-op pain assessment
- Write post-operative orders
- Dictate operative report
- Call referring physician regarding outcome of procedure and any unusual aspects of post-operative care (cardiac disease, diabetic management0

ost-op Same day work after discharge from recovery

- Examine patient, check bladder and patient progress
- Conduct post-op pain assessment
- Hand irrigate clots out of catheter
- Review patient hospital medical record notes (nursing, pharmacy, dietary, discharge planner)

- Answer patient and family questions
- Answer nursing and other staff questions
- Write any further necessary orders
- Write note in progress note section of medical record

Post-op Other Hospital Work – Beginning on post op-day 1, until discharge day

- Examine and talk to patient
- Conduct post-op pain assessment
- Check lab values
- Check catheter and irrigation, and irrigate as necessary
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of catheter at home with patient and family
- Answer nursing and other staff questions
- Answer patient and family questions
- Write any further necessary orders in medical record
- Write note in progress note section of medical record

Discharge day work:

- Examine patient and talk with patient and family
- Conduct post-op pain assessment
- Check catheter and patient progress
- Review all patient hospital medical records
- Answer patient and family questions
- Write orders for post-discharge care
- Write prescriptions for post-op medications
- Discuss post-op care of catheter with patient and family
- Dictate hospital discharge summary

Post-op Office work- After discharge from hospital:

- Examine patient, check vital signs
- Conduct post-op pain assessment
- Remove Foley catheter in office
- Talk with patient and family
- Patient to return to office next day to see if voiding satisfactorily
- Reinsert Foley catheter if unable to void
- In subsequent visits, examine patient, assess voiding pattern, check residual urine volume, check urinalysis and urine culture
- Write necessary prescriptions
- Schedule next office visit
- Dictate patient progress notes for office medical record
- Dictate letter to referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005		
Presenter(s):	Thomas P. Cooper, M.D.		
Specialty(s):	Urology		
CPT Code:	52601		
Sample Size:	588	**Resp n:** 56	**Response:** 9.5 %
Sample Type:	Random		

CPT Code:

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	10.34	12.50	**14.00**	15.50	27.00
Pre-Service Evaluation Time:			**35.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	45.00	60.00	**75.00**	90.00	120.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**40.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**68.0**	99231x **2.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**61.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
52648	090	11.19

CPT Descriptor Contact laser vaporization with or without transuretheral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
58660	090	11.27

CPT Descriptor 1 Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)

MPC CPT Code 2	Global	Work RVU
19318	090	15.60

CPT Descriptor 2 Reduction mammaplasty

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	**CPT Code: 52601**	**Key Reference CPT Code: 52648**
Median Pre-Service Time	60.00	60.00
Median Intra-Service Time	75.00	60.00
Median Immediate Post-service Time	40.00	60.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	68.0	0.00
Median Discharge Day Management Time	36.0	0.00
Median Office Visit Time	61.0	69.00
Median Total Time	**340.00**	**249.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.67	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.43
Urgency of medical decision making	2.95	2.76

Technical Skill/Physical Effort (Mean)

Technical skill required	4.57	3.67
Physical effort required	4.05	3.33

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.10
Outcome depends on the skill and judgment of physician	4.38	3.81
Estimated risk of malpractice suit with poor outcome	4.00	3.71

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.57	3.29
Intra-Service intensity/complexity	4.48	3.57
Post-Service intensity/complexity	3.67	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the survey data associated with each code and determine the final RUC recommendation.

With the advent and widespread use of medical therapy, the number of patients requiring TURP as initial treatment for BPH (benign prostatic hyperplasia) has decreased. As a consequence those patients who do undergo TURP are undergoing the procedure much later in their life when their prostate has enlarged considerably. Therefore the expert panel, felt that the 75th percentile of 15.50 and intraservice time of 75 minutes is more typical of this complex subset of rologic patients.

(see attached graph demonstrating decrease in volume of TURPs.)

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 38% No 63%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 9% I do not agree 91%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) 0% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 52601

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 2.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:55700 Global Period: 000 Specialty Society RVU: **2.83**
RUC RVU: **2.58**

CPT Descriptor: Biopsy, prostate; needle or punch, single or multiple, any approach

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old man has a persistent elevation of his PSA. Multiple sector biopsies of the prostate under local anesthesia are performed. Expectations and potential finding of the biopsies are discussed.

(NOTE: CPT 76872 "Ultrasound, transrectal" and CPT 76942 "Ultrasound guidance for needle placement" are separately billable.)

(NOTE: If an Evaluation and Management service is performed on the same day it is separately billable with a "-25" modifier.)

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 13%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Pre-Service Work - Day prior to procedure

Check schedule for following day
- Be sure necessary instruments and personnel will be available
- Be sure ultrasound machine is available and working
- Check with scheduling staff to see if patient was notified
- Review laboratory studies
- Be sure necessary imaging studies are available for review at time of planned procedure

Pre-Service work- Day of surgery:
- Change into scrub clothes
- Review procedure, post-op recovery with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Check to be sure patient has taken enema and pre-operative antibiotics
- Check to be sure patient is off of anti-coagulants and/or non-steroidal anti-inflammatory medications
- Position patient on exam/ultrasound table

Description of Intra-Service Work:
- Take "time out" for patient identification
- The patient is positioned on his left side with knees flexed (for a right handed urologist)
- Digital rectal exam is repeated, and anus is dilated
- The transrectal probe is introduced into the rectum
- Local anesthetic (typically 10 ccs of 1% Xylocaine) is infiltrated into the base of each seminal vesicle, and around both sides of the prostatic capsule and at both apices of the prostate.
- Typically a total of 12 sector biopsies are taken from the apex, base, peripheral zone, central zone and specific hypoechoic areas on both the right and left sides of the prostate.
- After each individual biopsy, the biopsy gun is removed from the transrectal probe (which remains in the rectum).
- Each specimen is removed from the biopsy needle and placed on the telfa pad.
- The gun is then recocked and reinserted through probe for next biopsy.

- Each of the 12 prostate biopsy samples is placed in a formalin filled container and each container appropriately labelled (patient identification information and location of biopsy)
- The rectal probe is removed. Rectal pressure is applied for an appropriate amount of time.

Description of Post-Service Work:
Description of Post-Service Work and
Post-op Same day work through discharge from recovery

- Assist in transfer of patient from operating table to post-op stretcher
- Review recovery area care and medications with staff
- Meet with patient and family; discuss the procedure, expected outcome, planned post operative care
- Conduct post-op pain assessment
- Discuss what the pathologist will do with the tissue and when the biopsy result will be available.
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate operative report

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005		
Presenter(s):	Thomas P. Cooper, M.D.		
Specialty(s):	Urology		
CPT Code:	55700		
Sample Size:	588	**Resp n:** 60	**Response:** 10 2 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	2.58	**2.58**	4.77	6.49
Pre-Service Evaluation Time:			**20.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
Intra-Service Time:	7.00	14.25	**15.00**	25.00	40.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**20.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
50200	000	2.63

CPT Descriptor Renal biopsy; percutaneous, by trocar or needle

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
36556	000	2.50

CPT Descriptor 1 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

MPC CPT Code 2	Global	Work RVU
43239	000	2.87

CPT Descriptor 2 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple

Other Reference CPT Code	Global	Work RVU
52275	000	4.69

CPT Descriptor Cystourethroscopy with Otis internal urethrotomy

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 58.3 %

TIME ESTIMATES (Median)	**CPT Code: 55700**	**Key Reference CPT Code: 50200**
Median Pre-Service Time	30.00	45.00
Median Intra-Service Time	15.00	53.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**65.00**	**113.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.26	3.34
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.17	3.34
Urgency of medical decision making	3.14	3.06

Technical Skill/Physical Effort (Mean)

Technical skill required	3.54	3.51
Physical effort required	3.11	3.03

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.20	3.46
Outcome depends on the skill and judgment of physician	3.40	3.37
Estimated risk of malpractice suit with poor outcome	3.29	3.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.09	3.11
Intra-Service intensity/complexity	3.37	3.26
Post-Service intensity/complexity	3.06	2.97

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our RUC recommendations are based on survey responses from urologists located across the country, including urologists from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of urologists comprised of a representative sample of the above described group convenes to examine the survey data associated with each code and determine the final RUC recommendation.

It is important to note that when this code was originally created by CPT more than 30 years ago, patients were taken to the OR under general anesthesia where one or two biopsies were done.

About 10 years ago with the introduction of modern third generation integrated ultrasound devices and technologically advanced biopsy instruments, the technique and results of prostate biopsy changed dramatically.

In addition, current urologic literature strongly supports the necessity of taking at least 12 biopsies.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 43% No 57%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 19% I do not agree 81%
B. Patients requiring this service are now:
   more complex (more work) 81% less complex (less work) 0% no change 19%
C. The usual site-of-service has changed:
   from outpatient to inpatient 4% from inpatient to outpatient 15% no change 81%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 55700

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		18.00	
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time 94%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		15.0		
Clinical Staff #1	Staff Type: RN/LPN/MTA	Intra Assist Physician Time: 14.0	Staff % of Physician time 94%	**Change: In Time** 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:57160 Global Period: 000 Specialty Society RVU: **1.60**

RUC RVU: **0.89**

CPT Descriptor: Fitting and insertion of pessary or other intravaginal support device

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 74 YO G4 P4 postmenopausal female presents with cystocele and uterine prolapse. In addition, she suffers from chronic obstructive pulmonary disease, which makes her a poor candidate for surgical intervention. Pelvic examination reveals that her prolapse is reducible and that she has no evidence of laceration or ulceration of her vaginal mucosa. The insertion of a pessary or intravaginal support device is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes:
-An explanation of the procedure is provided and informed consent is obtained.
-The patient is placed in the proper position.

Description of Intra-Service Work: Intra-service work includes:
- The patient is examined to determine the proper type and size of pessary.
  The pessary is fitted into the vagina; often multiple sizes have to be tried.
- The patient is examined for incontinence.
- Instruction on inserting and removing the pessary is given and the patient is oberved inserting and removing the pessary.
- The patient is allowed to walk around and then re-examined for fit of pessary.

Description of Post-Service Work: Post-service work includes:
-Patient instructions
- Instructions to patient for follow-up
-Consultation with family
- Dictation of procedure report
-Completion of patient report

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	George A. Hill, M.D., FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists					
CPT Code:	57160					
Sample Size: 0	**Resp n:** 0	**Response:** 0.00 %				
Sample Type:						
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:					

Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
ntra-Service Time:			**0.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
58100	000	1.53

CPT Descriptor Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
32000	000	1.54

CPT Descriptor 1 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent

MPC CPT Code 2	Global	Work RVU
29445	000	1.78

CPT Descriptor 2 Application of rigid total contact leg cast

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 21.2 %

TIME ESTIMATES (Median)

	CPT Code: 57160	Key Reference CPT Code: 58100
Median Pre-Service Time	0.00	20.00
Median Intra-Service Time	0.00	10.00
Median Immediate Post-service Time	0.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**0.00**	**35.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.14	3.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.43
Urgency of medical decision making	2.29	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.57
Physical effort required	3.14	2.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.14	2.57
Outcome depends on the skill and judgment of physician	4.14	3.29
Estimated risk of malpractice suit with poor outcome	2.00	3.29

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.86	2.86
Intra-Service intensity/complexity	3.43	3.29
Post-Service intensity/complexity	3.14	2.86

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
See attachment for Compelling Evidence Rationale and IWPUT

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 18% No 82%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 57160

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		14.00	
Clinical Staff #1	Staff Type: L037D	Intra Assist Physician Time: 9.0	Staff % of Physician time 64%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		15.0		
Clinical Staff #1	Staff Type: L037D	Intra Assist Physician Time: 10.0	Staff % of Physician time 64%	**Change: In Time** 1.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:57240 Global Period: 090 Specialty Society RVU: **10.90**

RUC RVU: **10.56**

CPT Descriptor: Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 YO G3 P3 presents with a mass bulging from her vagina which is made worse by standing for long periods of time or coughing. She had a hysterectomy 20 yrs ago and denies stress urinary incontinence. On exam she has an anterior midline defect that protrudes to the introitus with valsalva. She has good lateral, apical and posterior support. An anterior colporrhaphy is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

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
-Admit the patient to the hospital
-Prepare the hospital records and chart in accordance with hospital policy
Check on the patient, and review labs, x-rays and records prior to the surgery
-Physician scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient

Description of Intra-Service Work: Intra-service work includes:
-Incision in the anterior vagina from beneath the urethral meatus to the vaginal apex
- Dissection of the pubourethral and pubocervical tissue from the vaginal apex
-Closure of pubourethral tissue to complete repair of the urethrocele
- Closure of the pubocervical tissue to complete repair of the mid-line cystocele
- Excision of excess vaginal epithelium
-Bladder drainage
- Hemostatis
-Wound closure
-Application of dressings and packing
-Removal of manipulators, probes and packs

Description of Post-Service Work: Post-service work includes:
-Completion of operating room record
-Patient evaluation and stabilization
-Postoperative orders
-Dictation of operative report
-Consultation with family
-Hospital visits to assess patient status
Removal of packs, drains, catheters, sutures, staples
-Discharge care (review of laboratory reports, patient instructions, complete discharge summary/medical records
-Follow-up vists (review of pathology and laboratory reports, removal of packs, catheters, drainges, sutures, staples)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005				
Presenter(s):	George A. Hill, M.D., FACOG				
Specialty(s):	American College of Obstetricians and Gynecologists				
CPT Code:	57240				
Sample Size:	100	**Resp n:** 43	**Response:** 43.00 %		
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	6.50	10.56	**10.56**	12.00	14.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	20.00	45.00	**60.00**	60.00	90.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**68.0**	99231x **2.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**38.0**	99211x **0.0** 12x **1.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
45560	090	10.56

CPT Descriptor Repair of rectocele (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
44950	090	9.99

CPT Descriptor 1 Appendectomy

MPC CPT Code 2	Global	Work RVU
60220	090	11.88

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 62.7 %

TIME ESTIMATES (Median)	**CPT Code: 57240**	**Key Reference CPT Code: 45560**
Median Pre-Service Time	60.00	90.00
Median Intra-Service Time	60.00	90.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	68.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	38.0	38.00
Median Total Time	**292.00**	**352.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.43	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.00
Urgency of medical decision making	2.61	2.61

Technical Skill/Physical Effort (Mean)

Technical skill required	3.61	3.54
Physical effort required	3.43	3.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.96	2.93
Outcome depends on the skill and judgment of physician	3.64	3.57
Estimated risk of malpractice suit with poor outcome	2.86	2.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.89
Intra-Service intensity/complexity	3.36	3.36
Post-Service intensity/complexity	2.71	2.71

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

See attachment for Compelling Evidence Rationale and IWPUT

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 58% No 42%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 24% I do not agree 76%
B. Patients requiring this service are now:
   more complex (more work) 72% less complex (less work) 4% no change 24%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 28% no change 72%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 57240

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57250 | Global Period: 090 | **Recommended Work Relative Value**
Specialty Society RVU: **10.75**
RUC RVU: **10.56**

CPT Descriptor: Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70 YO G4 P4 presents for evaluation of a bulging mass and difficulty completely evacuating with defecation. She had a hysterectomy 10 yrs ago. This has become worse over the last several months and on exam she has a posterior midline defect, which protrudes past the introitus with valsalva. She has good anterior, apical, and lateral support. A posterior colporrhaphy is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

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
-Admit the patient to the hospital
-Prepare the hospital records and chart in accordance with hospital policy
Check on the patient, and review labs, x-rays and records prior to the surgery
-Physician scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient

Description of Intra-Service Work: Intra-service work includes:
-Incision in posterior vaginal epithelium
- Dissection of vaginal epithelium from underlying rectovaginal septum
- Dissection carried to vaginal apex superiorly and bilaterally to the levator musculature
- Rectal examination to delineate the extent of the defect
- Closure of the rectovaginal septum from the apex of the vagina to the distal vagina incorporating some of the levator musculature bilaterally
- Close the transverse perineal musculature to re-establish the perineal body
- Attach the distal rectovaginal septum to the perineal body
-Bladder drainage
-Hemostasis
-Wound closure
-Vaginal packing
-Application of dressings and packings
-Removal of manipulators, probes and packing

Description of Post-Service Work: Post-service work includes:
-Completion of operating room record
Patient evaluation and stabilization
-Postoperative orders
-Dictation of operative report
Consultation with family
-Hospital visits to assess patient status

-Removal of packs, drains, catheters, sutures, staples
-Discharge care (review of laboratory reports, patient instructions, complete discharge summary/medical records
-Follow-up vists (review of pathology and laboratory reports, removal of packs, catheters, draings, sutures, staples)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	George A. Hill, M.D., FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists					
CPT Code:	57250					
Sample Size:	100	**Resp n:** 51		**Response:** 51.00 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		10.00	10.56	**10.56**	11.50	13 00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		20.00	38.50	**60.00**	60.00	120 00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**68.0**	99231x **2.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**38.0**	99211x **0.0** 12x **1.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23), 99212 (15); 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
45560	090	10.56

CPT Descriptor Repair of rectocele (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
44950	090	9.99

CPT Descriptor 1 Appendectomy;

MPC CPT Code 2	Global	Work RVU
60220	090	11.88

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36 **% of respondents:** 70.5 %

TIME ESTIMATES (Median)

	CPT Code: 57250	**Key Reference CPT Code: 45560**
Median Pre-Service Time	60.00	90.00
Median Intra-Service Time	60.00	90.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	68.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	38.0	38.00
Median Total Time	**292.00**	**352.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.12	2.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.95	2.95
Urgency of medical decision making	2.35	2.32

Technical Skill/Physical Effort (Mean)

Technical skill required	3.49	3.41
Physical effort required	3.14	3.05

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.14	3.03
Outcome depends on the skill and judgment of physician	3.57	3.51
Estimated risk of malpractice suit with poor outcome	3 16	3.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.14	3.08
Intra-Service intensity/complexity	3.46	3.24
Post-Service intensity/complexity	2.96	2.86

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
See attachment for Compelling Evidence Rationale and IWPUT

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 39% No 61%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 10% I do not agree 90%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) 0% no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 10% no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 57250

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57260 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **16.28**
RUC RVU: **13.50**

CPT Descriptor: Combined anteroposterior colporrhaphy;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72 YO G2 P2 status post hysterectomy 25 yrs ago presents for evaluation of worsening vulvar pressure and a mass which protrudes from the vagina when she coughs or stands for a long period of time. She denies stress urinary incontinence but does have problems emptying with defecation. On examination she has an anterior midline defect and a posterior midline defect with good apical and lateral support of the vaginal cuff. An anterior and posterior colporrhaphy is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

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
-Admit the patient to the hospital
Prepare the hospital records and chart in accordance with hospital policy
-Check on the patient, and review labs, x-rays and records prior to the surgery
-Physician scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient

Description of Intra-Service Work: Intra-service work includes:
-Incision in posterior vaginal epithelium
- Dissection of vaginal epithelium from underlying rectovaginal septum
- Dissection carried to vaginal apex superiorly and bilaterally to the levator musculature
- Rectal examination to deliniate the extent of the defect
- Closure of the rectovaginal septum from the apex of the vagina to the distal vagina incorporating some of the lavator musculature bilaterally
- Close the transverse perineal musculature to re-establish the perineal body
- Attach the distal rectovaginal septum to the perineal body
- Bladder drainage
-Incision in the anterior vagina from beneath the urethral meatus to the vaginal apex
- Dissection of the pubourethral and pubocervical tissue from the vaginal apex
-Closure of pubourethral tissue to complete repair of the urethrocele
- Closure of the pubocervical tissue to complete repair of the midline cystocele
- Excision of excess vaginal epithelium
-Hemostasis
-Wound closure
-Vaginal packing
Application of dressings and packings
-Removal of manipulators, probes and packs

Description of Post-Service Work: Post-service work includes:
-Completion of operating room record

-Patient evaluation and stabilization
-Postoperative orders
-Dictation of operative report
Consultation with family
Hospital visits to assess patient status
-Removal of packs, drains, catheters, sutures, staples
-Discharge care (review of laboratory reports, patient instructions, complete discharge summary/medical records
-Follow-up vists (review of pathology and laboratory reports, removal of packs, catheters, draings, sutures, staples)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	George A. Hill, M.D., FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists					
CPT Code:	57260					
Sample Size:	100	**Resp n:** 46		**Response:** 46.00 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		8.00	12.50	**13.50**	13.50	16.00
Pre-Service Evaluation Time:				**45.0**		
Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		30.00	60.00	**90.00**	90.00	105.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**68.0**	99231x **2.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**38.0**	99211x **0.0** 12x **1.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38), 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
45560	090	10.56

CPT Descriptor Repair of rectocele (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
19318	090	15.60

CPT Descriptor 1 Reduction mammaplasty

MPC CPT Code 2	Global	Work RVU
34203	090	16.48

CPT Descriptor 2 Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 26.0 %

TIME ESTIMATES (Median)

	CPT Code: 57260	**Key Reference CPT Code: 45560**
Median Pre-Service Time	60.00	90.00
Median Intra-Service Time	90.00	90.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	
Median Other Hospital Visit Time	68.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	38.0	38.00
Median Total Time	**322.00**	**352.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.75	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.17
Urgency of medical decision making	3.00	2.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.08	3.58
Physical effort required	3.75	3.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	3.00
Outcome depends on the skill and judgment of physician	3.92	3.50
Estimated risk of malpractice suit with poor outcome	3.25	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.58	3.33
Intra-Service intensity/complexity	4.00	3.33
Post-Service intensity/complexity	3.17	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

See attachment for Compelling Evidence Rationale and IWPUT

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 49% No 51%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 18% I do not agree 82%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) 0% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 14% no change 86%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 57260

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57265 Global Period: 090 **Recommended Work Relative Value**
Specialty Society RVU: **19.34**
RUC RVU: **15.00**

CPT Descriptor: Combined anteroposterior colporrhaphy; with enterocele repair

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 YO status post hysterectomy 25 yrs ago presents for evaluation of worsening vulvar pressure and a mass which protrudes from the vagina when she coughs or stands for a long period of time she denies stress urinary incontinence but does have problems emptying with defecation On exam she is found to have an anterior midline defect and a midline posterior defect with a high bulging mass posteriorly consistent with an enterocele and rectocele. An anterior and posterior colporrhaphy with enterocele repair is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

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
-Admit the patient to the hospital
Prepare the hospital records and chart in accordance with hospital policy
-Check on the patient, and review labs, x-rays and records prior to the surgery
-Physician scrubs for the procedure, and waits for anesthesia induction and the preparation of the patient

Description of Intra-Service Work: Pre-service work includes:
- Incision in posterior vaginal epithelium
- Dissection of vaginal epithelium from underlying rectovaginal septum
- Dissection carried to vaginal apex superiorly and bilaterally to the levator musculature
- Rectal examination to delineate the extent of the defect
- Closure of the rectovaginal septum from the apex of the vagina to the distal vagina incorporating some of the levator musculature bilaterally
- Close the transverse perineal musculature to re-establish the perineal body
- Attach the distal rectovaginal septum to the perineal body
- Bladder drainage
- Incision in the anterior vagina from beneath the urethral meatus to the vaginal apex
- Dissection of the pubourethral and pubocervical tissue from the vaginal apex
- Closure of pubourethral tissue to complete repair of the urethrocele
- Closure of the pubocervical tissue to complete repair of the midline cystocele
- Excision of excess vaginal epithelium
- Further dissection is performed above the vaginal apex to delineate the enterocele sac
- The peritoneum is freed from the pubocervical tissue anteriorly and rectovaginal tissue posteriorly
- The enterocele (peritoneal) sac is entered sharply
Small bowel is pushed away and the enterocele sac is ligated high in the pelvis to obliterate it
- Excess peritoneum is excised distal to the ligation
- The anterior and posterior portions of the vaginal apex are reapproximated
- Hemostasis
- Wound closure

- Vagianl packing
- Application of dressings and packing
- Removal of manipulators, probes, and packs

Description of Post-Service Work: Post-service work includes:
-Completion of operating room record
-Patient evaluation and stabilization
-Postoperative orders
-Dictation of operative report
-Consultation with family
-Hospital visits to assess patient status
-Removal of packs, drains, catheters, sutures, staples
-Discharge care (review of laboratory reports, patient instructions, complete discharge summary/medical records
-Follow-up vists (review of pathology and laboratory reports, removal of packs, catheters, drainges, sutures, staples)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005				
Presenter(s):	George A. Hill, M.D., FACOG				
Specialty(s):	American College of Obstetricians and Gynecologists				
CPT Code:	57265				
Sample Size:	100	**Resp n:** 35	**Response:** 35.00 %		
Sample Type:	Convenience				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	10.00	12 00	**15.00**	15.00	18.00
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	35.00	60.00	**120.00**	120.00	180 00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**68.0**	99231x **2.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**38.0**	99211x **0.0** 12x **1.0** 13x **1.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
45560	090	10.56

CPT Descriptor Repair of rectocele (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
44160	090	18.59

CPT Descriptor 1 Colectomy, partial, with removal of terminal ileum with ileocolostomy

MPC CPT Code 2	Global	Work RVU
35656	090	19.50

CPT Descriptor 2 Bypass graft, with other than vein; femoral-popliteal

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)

	CPT Code: 57265	Key Reference CPT Code: 45560
Median Pre-Service Time	60.00	90.00
Median Intra-Service Time	120.00	90.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	68.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	38.0	38.00
Median Total Time	**352.00**	**352.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.86	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.14
Urgency of medical decision making	3.00	2.57

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.14
Physical effort required	3.57	2.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.57	2.71
Outcome depends on the skill and judgment of physician	3.86	3.00
Estimated risk of malpractice suit with poor outcome	3.57	2.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.29	2.86
Intra-Service intensity/complexity	4.00	3.00
Post-Service intensity/complexity	3.00	2.71

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
See attachment for Compelling Evidence Rationale and IWPUT

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 49% No 51%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 29% I do not agree 71%
B. Patients requiring this service are now:
   more complex (more work) 71% less complex (less work) 5% no change 24%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 18% no change 82%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 57265

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 1.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:57288 Global Period: 090 Specialty Society RVU: **13.00**

RUC RVU: **13.00**

CPT Descriptor: Sling operation for stress incontinence (eg, fascia or synthetic)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old woman has documented urinary incontinence and urethral dysfunction. After suitable counseling on the various treatment options, she elects to undergo a sling operation for stress incontinence (e.g. fascia or synthetic material).

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
Pre-Service work - Day before surgery

- Review pre op lab results
- Review medical record
- Write pre-op orders (to be emailed or faxed to hospital)

Pre-Service work - Day of surgery

- Change into scrub clothes
- Review surgical procedure, post-op recovery in and out of hospital with patient and family
- Answer patient and family questions, be sure informed consent is in record
- Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient (teeth, positioning, unusual medical problems)
- Take "time out" for patient identification
- Wait for anesthesiologist to administer anesthetic

Description of Intra-Service Work:

- Position patient in lithotomy position
- Prep lower abdomen and vagina
- Place Foley catheter, drain bladder
- Make vaginal incision (s)
- Develop perivesical space bilaterally
- Perforate the endopelvic fascia bilaterally
- Make suprapubic incision(s)
- Appropriately place fascial ligature carrier
- Properly position sling (fascia or synthetic)
- Suture sling in place under proper tension
- Close abdominal and vaginal incisions
- Place vaginal pack

Description of Post-Service Work:
Post-op same day through discharge from recovery

- Wait for anesthesiologist to awaken patient
- Transfer patient off operating table
- Place Foley catheter to drainage system
- Go with patient and anesthesiologist to recovery area bed

- Assist in transfer of patient to recovery bed
- Review recovery area care with staff
- Meet with patient's family and discuss the procedure, expected outcome, planned post-operative care in hospital and out of hospital
- Discuss procedure with patient as necessary in recovery area when awake
- Conduct post-op pain assessment
- Write post operative orders
- Call referring physician regarding outcome of procedure and any unusual aspects of post-operative care (cardiac disease, diabetic management)
- Dictate detailed operative report

Post-op other hospital work - beginning on post-op day one, until discharge day

- Examine patient
- Conduct post-op pain assessment
- Remove vaginal pack
- Check lab values
- Check catheter
- Review medical record
- Answer patient and family questions
- Answer nursing and staff questions
- Write any further necessary orders
- Write progress note

Discharge day work

- Examine and talk to patient and family
- Discuss post-operative care of catheter with patient and family
- Review all patient hospital medical records
- Review diet (avoid constipation)
- Write discharge orders
- Write prescriptions for post-operative medications
- Dictate discharge summary

Post-op work office - after discharge from hospital

- Examine patient and incisions, check vital signs
- Talk with patient and family
- Remove Foley catheter in office
- Voiding trial at appropriate post op visit
- Reinsert Foley catheter if unable to void
- Write necessary prescriptions
- Dictate office note
- Dictate letter to referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Thomas P. Cooper, M.D.				
Specialty(s):	AUA/ACOG				
CPT Code:	57288				
Sample Size:	588	**Resp n:** 37	**Response:** 6.2 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	7.59	12.00	**13.00**	14.00	17.50

CPT Code:

Pre-Service Evaluation Time:			**35.0**		
Pre-Service Positioning Time:			**10.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
ntra-Service Time:	20 00	45.00	**60.00**	90.00	120.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**40.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**49.0**	99231x **1.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**61.0**	99211x **0.0** 12x **1.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit. 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
53440	090	13.60

CPT Descriptor Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
44950	090	9.89

CPT Descriptor 1 Appendectomy

MPC CPT Code 2	Global	Work RVU
27870	090	13.89

CPT Descriptor 2 Arthrodesis, ankle, open

Other Reference CPT Code	Global	Work RVU
57289	090	11.56

CPT Descriptor Pereyra procedure, including anterior colporrhaphy

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 32.4 %

TIME ESTIMATES (Median)

	CPT Code: 57288	**Key Reference CPT Code: 53440**
Median Pre-Service Time	60.00	58.00
Median Intra-Service Time	60.00	100.00
Median Immediate Post-service Time	40.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	60.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	61.0	107.00
Median Total Time	**306.00**	**391.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.83	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.33
Urgency of medical decision making	3.08	3.08

Technical Skill/Physical Effort (Mean)

Technical skill required	3.83	3.75
Physical effort required	3.67	3.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.83	3.67
Outcome depends on the skill and judgment of physician	4.08	3.92
Estimated risk of malpractice suit with poor outcome	4.00	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.67	3.42
Intra-Service intensity/complexity	3.67	3.67
Post-Service intensity/complexity	3.83	3.58

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our RUC recommendations are based on a joint survey with responses from urologists and gynecologists located across the country, including physicians from single-specialty, multi-specialty and academic practices. Once responses are compiled, a panel of physicians comprised of a representative sample of the above described group convenes to examine the survey data associated with each code and determine the final RUC recommendation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 59% No 41%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 50% I do not agree 50%
B. Patients requiring this service are now:
   more complex (more work) 41% less complex (less work) 9% no change 50%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 50% no change 50%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 57288

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 2.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:57500 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **1.35**
RUC RVU: **1.20**

CPT Descriptor: Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37-year-old female presents to her physician with complaints of postcoital bleeding of several months duration. A Pap smear is obtained from the cervix. A pelvic examination is performed and two irregular, raised lesions are visualized on the cervix. Biopsies of the cervical lesions are recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes the following:
- Review of patient's chart
- Review of pap smear and related reports
- Obtain consent
- Confirm that colposcopic instruments are present and functioning properly

Description of Intra-Service Work: Intra-service work includes:
Insertion of speculum
-Visualization of cervix
-Biopsy of cervical lesion(s)
-Hemostasis

Description of Post-Service Work: Post-service work includes the following:
- Documentation of procedure
- Instructions to patient for follow-up
- Precautions against bleeding
- Review of pathology report
- Formulation of plan for follow-up treatment

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	George A. Hill, M.D., FACOG					
Specialty(s):	American College of Obstetricians and Gynecologists					
CPT Code:	57500					
Sample Size:	100	**Resp n:** 47		**Response:** 47.00 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.00	1.20	**1.20**	1.53	3.50
Pre-Service Evaluation Time:				**7.0**		
Pre-Service Positioning Time:				**1.0**		

Pre-Service Scrub, Dress, Wait Time:				1.0		
Intra-Service Time:		1.00	5.00	**15.00**	15.00	45.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
57100	000	1.20

CPT Descriptor Biopsy of vaginal mucosa; simple (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
45331	000	1.15

CPT Descriptor 1 Sigmoidoscopy, flexible; with biopsy, single or multiple

MPC CPT Code 2	Global	Work RVU
32000	000	1.54

CPT Descriptor 2 Thoracentesis, punture of pleural cavity for aspiration, initial or subsequent

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 36.1 %

TIME ESTIMATES (Median)

	CPT Code: 57500	Key Reference CPT Code: 57100
Median Pre-Service Time	9.00	15.00
Median Intra-Service Time	15.00	15.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**29.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.71	2.53
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.06	2.00
Urgency of medical decision making	2.71	2.59

Technical Skill/Physical Effort (Mean)

Technical skill required	2.41	2.47
Physical effort required	2.06	2.06

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.53	1.53
Outcome depends on the skill and judgment of physician	2.24	2.24
Estimated risk of malpractice suit with poor outcome	2.12	1.94

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.35	2.24
Intra-Service intensity/complexity	2.59	2.65
Post-Service intensity/complexity	2.12	2.12

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ee attachment for Compelling Evidence Rationale and IWPUT

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 23% No 77%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 18% I do not agree 82%
B. Patients requiring this service are now:
   more complex (more work) 55% less complex (less work) 0% no change 45%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 9% no change 91%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 57500

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		16.00	
Clinical Staff #1	Staff Type: L037D	Intra Assist Physician Time: 12.0	Staff % of Physician time 75%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		15.0		
Clinical Staff #1	Staff Type: L037D	Intra Assist Physician Time: 11.0	Staff % of Physician time 75%	**Change: In Time** 4.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:58120 Global Period: 010

Recommended Work Relative Value
Specialty Society RVU: **3.27**
RUC RVU: **3.27**

CPT Descriptor: Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)

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.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 26%

Is conscious sedation inherent in your reference code? No

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 patients 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

RUC Meeting Date (mm/yyyy)	09/2005		
Presenter(s):	George A. Hill, M.D., FACOG		
Specialty(s):	American College of Obstetricians and Gynecologists		
CPT Code:	58120		
Sample Size:	100	**Resp n:** 34	**Response:** 34.00 %
Sample Type:	Convenience		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.90	2.33	**3.27**	4.24	5.00
Pre-Service Evaluation Time:			**20.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		

Intra-Service Time:		5.00	15.00	**25.00**	30.00	60.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**27.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**18.0**	99238x **0.50**	99239x **0.00**			
Office time/visit(s):	**23.0**	99211x **0.0**	12x **0.0**	13x **1.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
58555	000	3.33

CPT Descriptor Hysteroscopy, diagnostic (separate procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
46221	010	2.04

CPT Descriptor 1 Hemorrhoidectomy, by simple ligature (e.g., rubber band)

MPC CPT Code 2	Global	Work RVU
51010	010	3.52

CPT Descriptor 2 Aspiration of bladder; with insertion of suprapubic catheter

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 32.3 %

TIME ESTIMATES (Median)

	CPT Code: 58120	**Key Reference CPT Code: 58555**
Median Pre-Service Time	35.00	30.00
Median Intra-Service Time	25.00	25.00
Median Immediate Post-service Time	27.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	18.0	0.00
Median Office Visit Time	23.0	0.00
Median Total Time	**128.00**	**75.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	2.82
Urgency of medical decision making	2.55	2.36

Technical Skill/Physical Effort (Mean)

Technical skill required	2.63	3.09
Physical effort required	2.45	2.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.45	2.45
Outcome depends on the skill and judgment of physician	2.82	3.36
Estimated risk of malpractice suit with poor outcome	3.00	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.91	3.00
Intra-Service intensity/complexity	2.82	3.18
Post-Service intensity/complexity	2.45	2.36

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists' (ACOG) convened a consensus expert panel to develop a work RVU recommendation for CPT code 58120.

After reviewing the survey data, the panel found no compelling reason to change the current RVW of 3.27.

The consensus panel did note that D&Cs are commonly performed in the non-facility settting and that the practice expense RVU for this service is very low.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 29% No 71%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 70% less complex (less work) 0% no change 30%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 20% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 58120

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25.00	
Clinical Staff #1	Staff Type: L037D	Intra Assist Physician Time: 25.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 1.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		25.0		
Clinical Staff #1	Staff Type: L037D	Intra Assist Physician Time: 25.0	Staff % of Physician time 100%	**Change: In Time** 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:** 0.5		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213: 1.0		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:58150 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **18.00**
RUC RVU: **15.98**

CPT Descriptor: Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 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.

Percentage of Survey Respondents who found Vignette to be Typical: 62%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 10%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patientþs 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 .o 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 sutured closed. The abdomen is closed in layers. 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 patients 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

RUC Meeting Date (mm/yyyy)	09/2005		
Presenter(s):	George A. Hill, M.D., FACOG		
Specialty(s):	American College of Obstetricians and Gynecologists		
CPT Code:	58150		
Sample Size:	100	**Resp n:** 63	**Response:** 63.00 %
Sample Type:	Convenience		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	11.66	15.98	**15.98**	20.00	23.32
Pre-Service Evaluation Time:			**45.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**10.0**		
Intra-Service Time:	45.00	95.00	**120.00**	150.00	300.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**87.0**	99231x **3.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**46.0**	99211x **0.0** 12x **0.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
58180	090	14.30

CPT Descriptor Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
34203	090	16.48

CPT Descriptor 1 Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg

MPC CPT Code 2	Global	Work RVU
44160	090	18.59

CPT Descriptor 2 Colectomy, partial, with removal of terminal ileum with ileocolostomy

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 36.5 %

TIME ESTIMATES (Median)

	CPT Code: 58150	**Key Reference CPT Code: 58180**
Median Pre-Service Time	60.00	60.00
Median Intra-Service Time	120.00	120.00
Median Immediate Post-service Time	30.00	40.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	87.0	87.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	46.00
Median Total Time	**379.00**	**389.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.13	3.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3 91	3.57
Urgency of medical decision making	3.57	3.30

Technical Skill/Physical Effort (Mean)

Technical skill required	4.52	4.09
Physical effort required	4.43	4.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.26	3.74
Outcome depends on the skill and judgment of physician	4.48	4.17
Estimated risk of malpractice suit with poor outcome	4.00	4.09

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.74	3.30
Intra-Service intensity/complexity	4.44	3.83
Post-Service intensity/complexity	3.57	3.43

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

,ee attachment for Compelling Evidence Rationale and IWPUT

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 49% No 51%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 87% less complex (less work) 0% no change 13%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 58150

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:58720 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **11.34**
RUC RVU: **11.34**

CPT Descriptor: Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

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.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service work includes taking a comprehensive history and performing a comprehensive examination to determine the patients 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. Oftentimes 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 patients 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

RUC Meeting Date (mm/yyyy)	09/2005		
Presenter(s):	George A. Hill, M.D., FACOG		
Specialty(s):	American College of Obstetricians and Gynecologists		
CPT Code:	58720		
Sample Size:	100	**Resp n:** 32	**Response:** 32.00 %
Sample Type:	Convenience		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	11.34	12.02	**11.34**	15.00	16.50
Pre-Service Evaluation Time:			**37.0**		

Pre-Service Positioning Time:				**5.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		45.00	60.00	**90.00**	90.00	120.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**30.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**49.0**	99231x **1.0**	99232x **1.0**	99233x **0.0**		
Discharge Day Mgmt:	**36.0**	99238x **1.00**	99239x **0.00**			
Office time/visit(s):	**38.0**	99211x **0.0**	12x **1.0**	13x **1.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
58925	090	11.34

CPT Descriptor Ovarian cystectomy, unilateral or bilateral

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
36832	090	10.48

CPT Descriptor 1 Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

MPC CPT Code 2	Global	Work RVU
60220	090	11.88

CPT Descriptor 2 Total thyroid lobectomy, unilateral; with or without isthmusectomy

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 43.7 %

TIME ESTIMATES (Median)

	CPT Code: 58720	**Key Reference CPT Code: 58925**
Median Pre-Service Time	52.00	60.00
Median Intra-Service Time	90.00	90.00
Median Immediate Post-service Time	30.00	35.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	49.0	49.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	38.0	46.00
Median Total Time	**295.00**	**316.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.86
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.64	3.43
Urgency of medical decision making	3.57	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.50
Physical effort required	3.86	3.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.86	2.93
Outcome depends on the skill and judgment of physician	3.86	3.36
Estimated risk of malpractice suit with poor outcome	3.57	3.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.64	3.50
Intra-Service intensity/complexity	3.64	3.36
Post-Service intensity/complexity	3.21	3.07

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American College of Obstetricians and Gynecologists (ACOG) convened a consensus expert panel to develop a work RVU recommendation for CPT code 58720.

After reviewing the survey data, the panel found no compelling reason to change the current RVW of 11.34.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 38% No 62%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 25% I do not agree 75%
B. Patients requiring this service are now:
   more complex (more work) 50% less complex (less work) 0% no change 50%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 42% no change 58%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 58720

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		0.00	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213: 1.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212: 1.0	
		99213: 1.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:61154 Global Period: 090 Specialty Society RVU: **14.97**

RUC RVU: **14.97**

CPT Descriptor: Burr Holes with evacuation and/or drainage of hematoma, extradural or subdural

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 77 year old man fell three weeks ago, striking his head but without loss of consciousness. He has had progressive headaches and more recently some speech impairment. Examination reveals drowsiness, expressive aphasia, and a right pronator drift. CT scan reveals a left panhemispheric hypodense subdural hematoma with midline shift. Paired burr holes are placed over the left frontoparietal region for hematoma evacuation. A subdural drain is placed for continued postoperative drainage of remaining fluid before the patient is transported to the intensive care unit. Postoperative hospital care and office visits are performed as appropriate through the 90 day global.

Percentage of Survey Respondents who found Vignette to be Typical: 30%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
The surgeon examined the patient in the hospital and identified localizing findings for the subdural hematoma including weakness and aphasia. Having made the recommendation for surgery, the surgeon consults with the cardiologist concerning the need for warfarin and with the intensivist regarding reversal of the anticoagulation. The patient is transfused with fresh-frozen plasma and the INR is intermittently checked until the anticoagulation is reversed. The family is counseled and gives informed consent for the surgery. The possibility of requiring a craniotomy is discussed. Anesthesia and the operating room are notified and the case posted. The patient is then transported to the operating room. After placing appropriate monitoring lines, the patient undergoes general anesthesia. The patient is positioned supine on the operating table with the head turned towards the right. The mandatory time-out procedure is followed. The CT is reviewed in the operating room and the left scalp is prepared for both burr hole drainage as well as possible craniotomy. The surgeon scrubs and the patient is draped in sterile fashion.

Description of Intra-Service Work: The two skin incisions are made and self retaining retractors placed. Meticulous hemostasis is achieved. Two burr holes are drilled using a high speed air drill. The bone edges are waxed and the dura coagulated. The dura is incised and a portion of the the subdural hematoma expresses itself. Saline irrigation is used repeatedly to wash the subdural space until clots and gross blood are removed. A subdural catheter is placed through the posterior burr hole and advanced toward the anterior burr hole over a Pennfield, being careful not to penetrate the brain. Several passes may be required to obtain ideal placement. The catheter is then irrigated to confirm communication between both holes through the catheter. The distal catheter is tunneled to an exit site where it is anchored with a suture and connected to a sterile drainage bag. The scalp incisions are then sewn closed. Sterile dressings are applied. The patient is transported to the intensive care unit.

Description of Post-Service Work: As the patient is transported back to the intensive care unit, the physician writes post-operative orders and an op note. The case is dictated. The family is counseled. The referring physician is called. The patient is examined in the intensive care unit and the nurses are instructed about the drainage bag. The intensivists are called and the patient's condition discussed with them. Coagulation studies are rechecked and a follow-up CT ordered. The physician then changes out of scrubs and leaves for the office.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Frederick Boop, MD				
Specialty(s):	Neurosurgery				
CPT Code:	61154				
Sample Size: 320	**Resp n:** 32	**Response:** 10.0 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	12.00	17.25	**14.97**	21.07	45 00
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**15.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:			**60.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**136.0**	99231x **4.0** 99232x **2.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**69.0**	99211x **0.0** 12x **0.0** 13x **3.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61313	090	24.89

CPT Descriptor Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
65750	090	14.98

CPT Descriptor 1 Keratoplasty (corneal transplant); penetrating (in aphakia)

MPC CPT Code 2	Global	Work RVU
34203	090	16.48

CPT Descriptor 2 Embolectomy or thrombectomy, with or without catheter, popliteal-tibio-peroneal artery, by leg incision

Other Reference CPT Code	Global	Work RVU
61533	090	19.68

CPT Descriptor Craniotomy with elevation of bone flap; for subdural implanation of an electrode array, for long term seizure monitoring

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 34.3 %

TIME ESTIMATES (Median)

	CPT Code: 61154	**Key Reference CPT Code: 61313**
Median Pre-Service Time	90.00	100.00
Median Intra-Service Time	60.00	150.00
Median Immediate Post-service Time	30.00	40.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	136.0	237.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	69.0	69.00
Median Total Time	**421.00**	**632.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.13	3.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.30
Urgency of medical decision making	4.03	3.87

Technical Skill/Physical Effort (Mean)

Technical skill required	2.87	3.43
Physical effort required	2.73	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.97	3.80
Outcome depends on the skill and judgment of physician	3.57	3.57
Estimated risk of malpractice suit with poor outcome	3.63	3.63

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.39	3.67
Intra-Service intensity/complexity	3.10	3.62
Post-Service intensity/complexity	3.48	3.45

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT Code 61154, Burr Holes for Evacuation of Epidural/Subdural Hematoma, was resurveyed by the AANS and CNS as part of the 2005 RUC Five year review process at the request of CMS. There were 30 respondents to the survey. The most frequently chosen reference service was 61313, Craniotomy for Evacuation of Intracerebral Hematoma, as a reference code. 61313 is a RUC surveyed code (8/95) with an intraservice time of 150 minutes, as compared to 61154 which has an intra-service time of 60 minutes. 61154 had previously been surveyed in the Harvard review and given an intra-service time of 69 minutes. At that time, it is was associated with a length of stay of 7 days and 14.97 RVWs . It

had an IWPUT of 0.086. In the new survey, the length of stay is 6 days, but there were multiple visits on several days (8 visits total). The median RVW in our current survey is 20, yielding an IWPUT of 0.164. Both of these values would create a rank order anomaly. On the other hand, the time data was very close to the Harvard data. Using the current work value in the RUC database of 14.97 with the surveyed time data, the calculated IWPUT of 0.080 is appropriate relative to this family of codes. The AANS/CNS do not believe that the new survey data show compelling evidence to change the value of the code. We therefore recommend that the RUC maintain the current value of this code at 14.97 but with the acceptance of the new RUC surveyed time data to replace the Harvard time data.

Building Block Method		RVW	
Proposed RVW		20.00	
Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	45	0.0224	1.01
Same day evaluation	15	0.0224	0.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59

Post-service	Time	Intensity	
Immediate post	30	0.0224	0.67

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)	
ICU 99291	0.0	4.00	0.00	
99233	0	1.51	0.00	
99232	2	1.06	2.12	
99231	4	0.64	2.56	
Discharge 99238	1.0	1.28		1.28
99215	0.0	1.73	0.00	
99214	0.0	1.08	0.00	
99213	3.0	0.65		1.95
99212	0.0	0.43		0.00
99211	0.0	0.17		0.00
Post-service total			8.58	

Time	Intra-service	60	IWPUT	0.164	RVW 9.83

Building Block Method		RVW	
Existing RVW		14.97	
Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	45	0.0224	1.01
Same day evaluation	15	0.0224	0.34
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59

Post-service	Time	Intensity	
Immediate post	30	0.0224	0.67

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)	
ICU 99291	0.0	4.00	0.00	
99233	0	1.51	0.00	
99232	2	1.06	2.12	
99231	4	0.64	2.56	
Discharge 99238	1.0	1.28		1.28

99215	0.0		1.73	0.00
99214	0.0	1.08		0.00
99213	3.0	0.65		1.95
99212	0.0	0.43		0.00
99211	0.0	0.17		0.00
Post-service total			8.58	

Time Intra-service 60 IWPUT 0.080 4.80

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 20% No 80%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 61154

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:61312 Global Period: 090 Specialty Society RVU: **27.00**

RUC RVU: **27.00**

CPT Descriptor: Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 28 year old man is found unconscious at the scene of a motor vehicle accident. Examination reveals a dilated pupil and decerebrate posturing. He is intubated, hyperventilated, and given mannitol and lasix. CT demonstrates a 1.5 cm acute subdural hematoma over the left hemisphere with 2 cm of left to right shift. The patient was evaluated by the trauma team and felt to have an isolated head injury with a normal coagulation profile. A large left frontal temporoparietal craniotomy is performed for evacuation of an acute subdural hematoma and control of bleeding from contused cortex and a lacerated vein. An ICP monitor is placed (separately reported if placed at separate site) before transporting the patient to the intensive care unit. Postoperative hospital care and office visits are performed as appropriate through the 90 day global.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The surgeon had previously examined the patient in the emergency room and determined that the patient had a traumatic subdural hematoma requiring emergent evacuation. Temporizing measures of hyperventilation, mannitol and Lasix were instituted. The surgeon consults with the trauma surgeon concerning other organ system injuries. The family is counseled and gives informed consent for the surgery on behalf of the patient. Anesthesia and the operating room are notified and the case posted. Coagulation studies are reviewed and abnormalities treated. The patient is then transported to the operating room. After placing appropriate monitoring lines, the patient undergoes general anesthesia. The patient is positioned supine on the operating table with the head turned towards the right. The mandatory time-out procedure is followed. The CT is reviewed in the operating room and the left scalp is prepared for craniotomy. The surgeon scrubs and the patient is draped in sterile fashion.

Description of Intra-Service Work: A trauma flap incision is made and self retaining retractors placed. Meticulous hemostasis of the scalp is achieved. Several burr holes are drilled using a high speed air drill and a craniotomy flap is cut. The bone edges are waxed. Several small dural incisions are made around the perimeter and a portion of the the subdural hematoma expresses itself. Upon confirming that the brain swelling is not excessive, the dural incisions are connected and a dural flap is turned. Saline irrigation is used repeatedly to wash the subdural space until clots and gross blood are removed. Inspection under the bone flap is also performed to remove any additional blood. The brain surface is inspected for a bleeding source, and this is coagulated if identified. Contused areas of brain are covered with hemostatic agent as appropriate. Communication with the anesthesiologist is periodically made concerning hyperventilation, urine output, blood pressure, and blood loss. A subdural catheter may be placed through a burr hole for additional postoperative drainage. An intracranial pressure monitor may be placed at a separate site if indicated (separately reported). The distal catheter is tunneled to an exit site where it is anchored with a suture. Drill holes are placed around the perimeter of the skull and dural tack up sutures are placed. The bone flap is replaced if significant brain swelling is not observed and secured to the skull with plates or sutures. The scalp is closed in layers. Sterile dressings are applied. The subdural drain is connected to a drainage bag. The patient is transported to the intensive care unit.

Description of Post-Service Work: As the patient is transported back to the intensive care unit, the physician writes post-operative orders and an op note. The case is dictated. The family is counseled. The referring physician is called. The patient is examined in the intensive care unit and the nurses instructed as to the drainage bag. The intensivists are

called and the patient's condition discussed with them. The physician then changes out of scrubs and leaves for the office

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Frederick Boop, MD					
Specialty(s):	Neurosurgery					
CPT Code:	61312					
Sample Size:	320	**Resp n:** 32		**Response:** 10.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		19.50	25.00	**27.00**	30.00	45.00
Pre-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:				**150.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**275.0**	99231x **6.0** 99232x **4.0** 99233x **1.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**46.0**	99211x **0.0** 12x **0.0** 13x **2.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61313	090	24.89

CPT Descriptor Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
61510	090	28.41

CPT Descriptor 1 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except menigioma

MPC CPT Code 2	Global	Work RVU
44626	090	25.32

CPT Descriptor 2 Closure of entersotomy, large or small intestine; with resection and colorectal anastomosis

Other Reference CPT Code	Global	Work RVU
61305	090	26.57

CPT Descriptor Craniectomy or craniotomy, exploratory; infratentorial (posterior fossa)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)

	CPT Code: 61312	Key Reference CPT Code: 61313
Median Pre-Service Time	90.00	100.00
Median Intra-Service Time	150.00	150.00
Median Immediate Post-service Time	30.00	40.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	275.0	237.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	46.0	39.00
Median Total Time	**627.00**	**602.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.43	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	3.33
Urgency of medical decision making	4.80	4.47

Technical Skill/Physical Effort (Mean)

Technical skill required	3.83	3.80
Physical effort required	3.60	3.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.60	4.50
Outcome depends on the skill and judgment of physician	4.07	3.97
Estimated risk of malpractice suit with poor outcome	4.27	4.17

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.03	3.93
Intra-Service intensity/complexity	4.03	3.93
Post-Service intensity/complexity	4.31	4.03

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

CPT Code 61312, Craniotomy for Evacuation of Epidural/Subdural Hematoma, was resurveyed by the AANS and CNS as part of the 2005 RUC Five year review process at the request of CMS. There were 30 respondents to the survey. The most frequently chosen reference code was 61313, Craniotomy for Evacuation of Intracerebral Hematoma. 61313 is a RUC surveyed code (8/95)with an intraservice time of 150 minutes, identical to the newly surveyed intraservice time of 150 minutes (intra-service time was 120 when originally surveyed). This represents an additional 30 minutes of intra-service work. 61313 has a length of stay of 10 days, whereas 61312 has an average length of stay of 13 days. The

RVW for 61313 is 24.89, with a calculated IWPUT of 0.068. The median RVW for 61312 is 27, yielding an IWPUT for 61312 of 0.077. Given the new survey data showing that the intra-service time for this procedure has increased (the effects of contemporary anticoagulants like Plavix and higher levels of anticoagulation from Coumadin make emergent intra-operative hemostasis more technically demanding and time-consuming) and that the length of stay has not significantly changed, our new survey data would support an increase in value for this service. The AANS/CNS recommend the median survey value of 27 for code 61312, which would keep the IWPUT and value in the appropriate range.

CPT	Ref	IWPUT	25th	50th	75th	Intra-time	SD
SVY	61312	0.077	25	27	30	150	30
OLD	61312	0.076		24.53		120	45
REF	61313	0.068		24.89		150	40

Building Block Method			RVW
Proposed RVW		27.00	

Pre-service Time		Intensity	(=time x intensity)
Day prior evaluation	30	0.0224	0.67
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			1.59

Post-service Time		Intensity	
Immediate post	30	0.0224	0.67

Subsequent visits:		Visit n	E/M RVU	(=n x E/M RVU)
ICU 99291	0.0	4.00	0.00	
99233	1.0	1.51	1.51	
99232	5.0	1.06	5.30	
99231	6.0	0.64	3.84	
Discharge 99238		1.0	1.28	1.28
99215	0.0	1.73	0.00	
99214	0.0	1.08	0.00	
99213	2.0	0.65	1.30	
99212	0.0	0.43	0.00	
99211	0.0	0.17	0.00	
Post-service total				13.90

	Time	IWPUT	
Intra-service	150	0.077	11.51

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 16% No 84%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 61312

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61537 | Global Period: 090 | **Recommended Work Relative Value** Specialty Society RVU: **35.00** RUC RVU: **35.00**

CPT Descriptor: Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24-year-old woman presents with chronic, intractable complex partial seizures. She previously had undergone an extensive evaluation with long-term video EEG analysis of her seizures that had clearly identified the seizure focus in the right temporal lobe. At operation, her right temporal lobe, including the amygdala and anterior hippocampus, are removed (without intraoperative electrocorticography). Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service, after decision to operate and prior to the day of surgery:
Plan and review the surgical approach which will allow entrance to the skull, and to carefully remove the temporal lobe that is responsible for the patient's seizures; Review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Obtain informed consent; Confirm that all specialized equipment will e available in the operating room.Dictate a letter to the referring physician and call the referring physician to discuss the proposed surgery
Pre-service, day of surgery:
Greet the patient in the pre-operative holding area and answers any final questions from the family; Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Review planned incisions and procedure; Locate, review, and place MRI and films on the view box in the operating room; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Accompany patient to operating room; Change into scrub clothes; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of general anesthesia; After general anesthesia is induced, the patient's scalp is shaved at the site of the incision.; Apply a Mayfield pin head holder to the patient's head; Position the patient with the right shoulder elevated and the patient's head turned to the left -positioning of the patient is completed so that there is not any unusual pressure on neurovascular structures; Prep the patient; Scrub and gown; Mark the incisions and supervise draping of the patient

Description of Intra-Service Work: An incision is made and hemostasis achieved with retraction and electrocautery. Burr holes are made at the periphery of the exposure and connected using the craniotome. The bone flap is elevated and the dura is exposed. The dura is opened with sharp dissection and the dural edges are retracted. The neurosurgeon measures the temporal lobe from its anterior extent and determines where the cortical incisions will be made. After cortical incisions are made, a dissection is made deep to the cortex with the ultrasonic aspirator. This dissection is made in the coronal plane approximately 4 cm from the anterior tip of the temporal lobe until the temporal horn of the lateral ventricle and the hippocampus are identified. The dissection then spares these medial structures for the time being. When the pia of the medial cortex is encountered, a sub-pial dissection is made. The pia is then coagulated with bipolar coagulation and opened with sharp dissection. The anterior and lateral portion of the temporal lobe is then removed, leaving the mesial temporal structures. A very careful and delicate dissection is then made of the hippocampus, nygdala and uncus. Great care is taken to identify, coagulate and divide perforating arteries from the posterior erebral artery to the hippocampus without damaging the posterior cerebral artery. Great care is also taken to preserve the anterior choroidal artery and the pia-arachnoid overlying the ambient cistern which contains the internal carotid artery, the posterior cerebral artery, the third, fourth, fifth and sixth cranial nerves, the basilar vein of Rosenthal, the optic tract, the lateral geniculate, and the brainstem. Hemostasis is achieved. The dura is sutured so that it is watertight.

The bone flap is replaced and secured to the surrounding bone with titanium plates and screws. The temporalis muscle is sutured together and then the galea and skin are closed.

Description of Post-Service Work: Post-service, day of surgery:
The patient's head is removed from three-point fixation and sterile dressings are applied; Write an OP note in the patient's record; Monitor for abnormal neurological findings ; Sign OR forms, including pre- and postoperative diagnosis, operations performed; Discuss procedure outcome with family; Dictate postop report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company; Call referring physician to discuss the surgery; Order and review films and a CT of the head to ensure that there is no postoperative hemorrhage and that there are no new, unexpected findings; Order and review blood and serum analysis and adjust anti-seizure medication as necessary; Consult with epilepsy team in intensive care unit

Post-service, hospital, after day of surgery, through discharge:
Write orders to transfer patient to acute care floor, when appropriate; Write orders for post-op labs, films, medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other staff patient chart notes; Chart patient progress notes; Discuss patient progress with referring physician (verbal and written); Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions; At discharge, review post-discharge wound care and activity limitations with patient/family; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge labs, films, and medications; Chart patient discharge notes

Post-service, office:
Take telephone calls from patient/family regarding questions about persistent headache; Write orders for medications and follow-up CT; Review post-discharge CT; Examine patient, check patient progress; Remove sutures, when appropriate; Dictate patient progress notes for medical chart; Answer mother/family questions, insurance staff questions; Discuss patient progress with referring physician and epileptologist (verbal and written)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Frederick Boop, MD					
Specialty(s):	Neurosurgery					
CPT Code:	61537					
Sample Size:	0	**Resp n:** 0		**Response:** 0.0 %		
Sample Type:						
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:						
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:				**0.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61510	090	28.41

CPT Descriptor Craniectomy, trephination, bone flap craniotomy; for exdision of brain tumor, supratentorial, except menigioma

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
20824	090	30.89

CPT Descriptor 1 Replantation, thumb (includes carpometacarpal joint to MP Joint), complete amputation

MPC CPT Code 2	Global	Work RVU
43117	090	39.94

CPT Descriptor 2 Partial esophagectomy, distal two-thirds, with thoracotomy and separate abdominal incision, with or without proximal gastrectomy; with thoracic esophagogastrostomy, with or without

Other Reference CPT Code	Global	Work RVU
61536	090	35.47

CPT Descriptor Craniotomy with elevation of bone flap; for excision of cerebral epileptogenic focus, with electrocorticography during surgery (inlcudes removal of electrode array)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 3 **% of respondents:** 25 %

TIME ESTIMATES (Median)

	CPT Code: 61537	**Key Reference CPT Code: 61510**
Median Pre-Service Time	0 00	105.00
Median Intra-Service Time	0.00	200.00
Median Immediate Post-service Time	0.00	40.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	136.00
Median Discharge Day Management Time	0.0	36.00
Median Office Visit Time	0.0	92.00
Median Total Time	**0.00**	**609.00**
ther time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.92	3.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.92	4.27
Urgency of medical decision making	3.00	3.36

Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.09
Physical effort required	3.75	3.82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.50	4.18
Outcome depends on the skill and judgment of physician	4.75	4.45
Estimated risk of malpractice suit with poor outcome	4.33	4.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.17	3.91
Intra-Service intensity/complexity	4.33	4.00
Post-Service intensity/complexity	3.42	3.27

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The CPT Editorial Panel created the limited temporal resection and lobectomy without electrocorticography codes to escribe the recent advances in neuroimaging which have allowed lobectomies to safely done without electrocorticography. In addition, new codes and revisions to existing codes were developed to describe the latest techniques which have been developed for limited temporal lobe resection, functional hemispherectomy, and multiple subpial transections.

61537

The RUC examined code 61537 Craniotomy with elevation of bone flap; for lobectomy, temporal lobe, without electrocorticography during surgery. It was determined by the RUC after reviewing reference code 61538 Craniotomy with elevation of bone flap; for lobectomy, with electrocorticography during surgery, temporal lobe (RVU = 26.81) that he intra-service time of the new code (intra-service time = 240 minutes) is higher than the intra-service time of the reference code (intra-service time 210 minutes). In addition, the intra-service period of the new code was deemed more intense than the reference code. This time and intensity difference between these two codes lead the society to realize that the reference code was undervalued. The initial value of the code was RUC surveyed, but was based upon data of 3 surveys. As such, the AANS/CNS sought to resurvey both codes at this 5-year review recognizing that the number of cases done nationally is small. The new survey data is based upon 14 survey respondents, with the average respondent performing 11 cases per year. This is in keeping with the RUC database which shows 164 of these cases having been performed last year.

The current survey data reflects that both codes were undervaluedwas reflected within the specialty society's survey which had a median RVW of 27.66. However, the RUC agreed with the specialty society that the 25th percentile RVW for 61537 is appropriate as it maintains the relativity to the reference code 61538. Therefore, the RUC recommends a work relative value of 25.00 for 61537.

Building Block Method	RVW
Proposed RVW	35.00

Pre-service	Time	Intensity	(time x intensity)
Day prior evaluation	60	0.0224	1.34
Same day evaluation	20	0.0224	0.45
Scrub, prep	50	0.0081	0.41
Pre-service total			2.20

Post-service	Time	Intensity	
Immediate post	45	0.0224	1.01

Subsequent visits:		Visit n	E/M RVU	(=n x E/M RVU)
ICU 99291	0.0	4.00	0.00	
99233	0.0	1.51	0.00	
99232	2.0	1.06	2.12	
99231	3.0	0.64	1.92	
Discharge 99238	1.0	1.28	1.28	
99215	0.0	1.73	0.00	
99214	0.0	1.08	0.00	
99213	3.0	0.65	1.95	
99212	0.0	0.43	0.00	
99211	0.0	0.17	0.00	
Post-service total				8.28

Time		IWPUT	
Intra-service	285	0.086	24.53

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. When microdissection utilizing the operating microscope is necessary, code 69990 would be reported as an add-on code.

3.

CPT	Glob	2005 RVW	Pre-time	Intra Time	Post-time
61537	090	24.96	125	265	219
69990	ZZZ	3.47 n/a*			
Total		28.43			

8. *69990 Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure) A specific intra-operative time is not associated with this code. Use of the operating microscope will add time and intensity to any operation, when employed.

9.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 33% No 64%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 61537

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212: 1.0	
		99213: 2.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61697 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **61.48**
RUC RVU: **57.31**

CPT Descriptor: Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman presents with severe headache, nausea, vomiting and decreased level of consciousness. A CT brain scan demonstrates diffuse subarachnoid hemorrhage and an angiogram discloses the source of the hemorrhage as a 2.5 cm aneurysm arising from the right internal carotid artery apex with a wide neck and intraluminal thrombus. The patient undergoes a craniotomy for clipping of the intracranial aneurysm. Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service includes: a review of the angiogram, imaging studies, appropriate lab studies; extensive informed consent with the patient and family; plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup; and positioning is lengthy due to stabiliazation of the patient's head in a pin fixation device.

Description of Intra-Service Work: A scalp flap is outlined and reflected over the fronto-temporal region. After division of the overlying muscles and exposure of the bone, the bone is removed to expose the sphenoid ridge and orbital roof. The dura is opened and retracted, exposing the frontal and temporal lobes. The aneurysm is exposed by dissection and opening of the Sylvian fissure. The vessels are carefully exposed and the neck of the aneurysm is identified. Exposure of the neck of the aneurysm may necessitate dissection of vessels incorporated into the neck or placement of temporary occlussion clips. 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.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Frederick Boop				
Specialty(s):	Neurosurgery				
CPT Code:	61697				
Sample Size:	275	**Resp n:** 41	**Response:** 14.9 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**

Survey RVW:	49.00	59.50	**57.31**	65.00	120.00
Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**30.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
Intra-Service Time:	180.00	240.00	**300.00**	360.00	480.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**50.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**480.0**	99231x **5.0** 99232x **6.0** 99233x **5.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**84.0**	99211x **0.0** 12x **0.0** 13x **2.0** 14x **1.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61682	090	61.48

CPT Descriptor Surgery of intracranial arteriovenous malformation; supratentorial, complex

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
47130	090	53.27

CPT Descriptor 1 Hepatectomy, resection of liver; total right lobectomy

MPC CPT Code 2	Global	Work RVU
20808	090	61.56

CPT Descriptor 2 Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation

Other Reference CPT Code	Global	Work RVU
61686	090	64.39

CPT Descriptor Surgery of intracranial arteriovenous malformation; infratentorial, complex

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 48.7 %

TIME ESTIMATES (Median)	CPT Code: 61697	Key Reference CPT Code: 61682
Median Pre-Service Time	105.00	120.00
Median Intra-Service Time	300.00	420.00
Median Immediate Post-service Time	50.00	50.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	480.0	182.00
Median Discharge Day Management Time	36.0	1.00
Median Office Visit Time	84.0	46.00
Median Total Time	**1055.00**	**819.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.20	4.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.32	4.33
Urgency of medical decision making	4.80	3.79

Technical Skill/Physical Effort (Mean)

Technical skill required	4.93	4.87
Physical effort required	4.46	4.59

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.90	4.77
Outcome depends on the skill and judgment of physician	4.93	4.92
Estimated risk of malpractice suit with poor outcome	4.37	4.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.58	4.37
Intra-Service intensity/complexity	4.85	4.74
Post-Service intensity/complexity	4.73	4.39

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have requested review f a family of four intracranial aneurysm codes during this five year review process. The two base codes in this family 61700 Surgery of intracranial aneurysm, intracranial approach; carotid circulation and 61702 Surgery of intracranial aneurysm, intracranial approach; vertebrobasilar circulation were originally surveyed by our society in 1995 as part of the first five year review of the RBRVS. Subsequently in 2001 these codes were changed and two new codes were added to better define the work associated with the operative repair of intracranial aneurysm. Each of the exisiting codes were

divided into a simple and complex aneurysm to account for the large variations in physician work associated with different aneurysms. This resulted in four codes within this family:

61697 Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation
61698 Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation
61700 Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation
61702 Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation.

When these new codes were brought to the RUC it was difficult to predict the distribution of cases between the simple and complex codes making budget neutrality calculations impossible. Therefore the decision was made to value the simple and complex codes the same as the original base codes and collect volume data for several years prior to surveying and valuing the new codes.

Also at this time it was recognized that a potential rank order anomaly existed in this family of codes with the less complex carotid circulation aneurysms being valued greater than vertebrobasilar circulation aneurysms. In an effort to determine if this was in fact the case we surveyed the entire family of codes in the summer of 2004 when we needed to survey the new complex aneurysm codes, 61697 and 61698. What this preliminary survey data showed was that in addition to the rank order anomaly, the entire family of codes appeared to be undervalued because of significant underestimation of postoperative work in the 90 day global period in the original survey. Given that the changes to 61700 and 61702 were considered editorial, we could only have given the RUC recommendations on the new codes of 61697 and 61698 which would have created further anomalies in this family of codes with the potential of misvaluing the entire family of codes. Therefore we withdrew those codes form the RUC with the intention of bringing the entire family of codes to the five year review for survey.

This new survey data gives compelling evidence of previous misevaluation of this family of codes. The data confirms that there is a rank order anomaly between 61700 and 61702 under the current values.

Existing RVW 61700	50.44	Median Survey RVW 61700	52.0
Existing RVW 61702	48.34	Median Survey RVW 61702	60.0

An analysis of the IWPUT further shows some difference between the intraservice portion of the reference service time data and the survey data with the reference service having a longer intraservice time. However this difference in intraservice work is compensated for by significantly more postoperative work within the 90 day global period for the survey code.

Building Block Method	RVW
61697 Proposed RVW	61.48

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	90	0.0224	2.02
Same day evaluation	30	0.0224	0.67
Scrub, prep	60	0.0081	0.49
Pre-service total			3.17

Post-service	Time	Intensity	
Immediate post	60	0.0224	1.34

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)		
ICU 99291	1.0	4.00		4.00	
99233	4.0	1.51			6.04
9232	6.0	1.06			6.36
99231	5.0	0.64		3.20	
Discharge 99238	1.0	1.28		1.28	

99215	0.0	1.73	0.00	
99214	1.0	1.08	1.08	
99213	2.0	0.65	1.30	
99212	0.0	0.43	0.00	
99211	0.0	0.17	0.00	
Post-service total			24.60	

Intra-serviceTime	300	IWPUT	0.112

Building Block Method		RVW	
61682 Survey RVW		61.48	

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	60	0.0224	1.34
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.24
Pre-service total			2.26

Post-service	Time	Intensity	
Immediate post	50	0.0224	1.12

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)	
ICU 99291	0	4.00	0.00	
99233	0	1.51	0.00	
99232	1	1.06		1.06
99231	8	0.64		5.12
Discharge 99238	1.0	1.28		1.28
99215	0.0	1.73		0.00
99214	0.0	1.08	0.00	
99213	2.0	0.65		1.30
99212	0.0	0.43		0.00
99211	0.0	0.17		0.00
Post-service total			9.88	

Time	Intra-service	420	IWPUT	0.117

This additional work within the postoperative period may be accounted for by changing practice patterns. Over the past ten to fifteen years there has been a trend toward early surgery in the treatment of ruptured aneurysms. In the past, aneurysms, particularly of the vertebrobasilar circulation, would be treated in a delayed fashion after recovering from the subarachnoid hemorrhage. This resulted in shorter length of stay with more work in the pre-op non-global period. However, there has been increasing recognition that the risks of rehemorrhage outweighs the risks of early surgery in most patients so that now almost all patients are treated in the acute phase after their subarachnoid hemorrhage(SAH). Therefore the period of recovery from the SAH with the attendant risk of cerebral vasospasm now falls in the postop global period. We believe this explains the increased number and acuity of postoperative visits in the current survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
3. When microdissection utilizing the operating microscope is necessary, code 69990 would be reported as an add-on code.
4.
5.

CPT	Glob	Proposed RVW	Pre-time	Intra Time	Post-time
61702	090	60	120	280	60
69990	ZZZ	3.47	n/a*		
Total		63.47			

9.
10. *69990 Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure) A specific intra-operative time is not associated with this code. Use of the operating microscope will add time and intensity to any operation, when employed

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 17% No 83%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 61697

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 2.0	
		99214: 1.0	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61700 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **52.00**
RUC RVU: **46.01**

CPT Descriptor: Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old woman has a sudden onset of severe headache with a brief period of unconsciousness. A CT scan shows diffuse subarachnoid hemorrhage in the basal cisterns and an angiogram shows a 0.8 cm aneurysm of the anterior communicating artery. The patient undergoes a craniotomy for clipping of the intracranial aneurysm. Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service includes: a review of the angiogram, imaging studies, appropriate lab studies; extensive informed consent with the patient and family; plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup; and positioning is lengthy due to stabiliazation of the patient's head in a pin fixation device.

Description of Intra-Service Work: A scalp flap is outlined and reflected over the fronto-temporal region. After division of the overlying muscles and exposure of the bone, the bone is removed to expose the sphenoid ridge and orbital roof. The dura is opened and retracted, exposing the frontal and temporal lobes. The aneurysm is exposed by dissection and opening of the Sylvian fissure. 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.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Frederick Boop					
Specialty(s):	Neurosurgery					
CPT Code:	61700					
Sample Size:	275	**Resp n:** 44		**Response:** 16.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		30.66	45.00	**46.01**	57.50	70.00

Pre-Service Evaluation Time:				**60.0**		
Pre-Service Positioning Time:				**30.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		120.00	180.00	**240.00**	248.00	360.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**40.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**349.0**	99231x **5.0** 99232x **3.0** 99233x **4.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**84.0**	99211x **0.0** 12x **0.0** 13x **2.0** 14x **1.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61520	090	54.76

CPT Descriptor Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
20973	090	45.69

CPT Descriptor 1 Free osteocutaneous flap with microvascular anastomosis; great toe with web space

MPC CPT Code 2	Global	Work RVU
20808	090	61.56

CPT Descriptor 2 Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation

Other Reference CPT Code	Global	Work RVU
61682	090	61.48

CPT Descriptor Surgery of intracranial arteriovenous malformation; supratentorial, complex

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 25.0 %

TIME ESTIMATES (Median)

	CPT Code: 61700	Key Reference CPT Code: 61520
Median Pre-Service Time	105.00	120.00
Median Intra-Service Time	240.00	360.00
Median Immediate Post-service Time	40.00	45.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	349.0	144.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	84.0	92.00
Median Total Time	**854.00**	**797.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.72	3.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	4.03
Urgency of medical decision making	4.58	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	4 44	4.43
Physical effort required	4.00	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.70	4.40
Outcome depends on the skill and judgment of physician	4.67	4.63
Estimated risk of malpractice suit with poor outcome	4.37	4.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.14	4.00
Intra-Service intensity/complexity	4.26	4.32
Post-Service intensity/complexity	4 07	3.58

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have requested review f a family of four intracranial aneurysm codes during this five year review process. The two base codes in this family 61700 Surgery of intracranial aneurysm, intracranial approach; carotid circulation and 61702 Surgery of intracranial aneurysm, intracranial approach; vertebrobasilar circulation were originally surveyed by our society in 1995 as part of the first five year review of the RBRVS. Subsequently in 2001 these codes were changed and two new codes were added to better define the work associated with the operative repair of intracranial aneurysm. Each of the exisiting codes were

divided into a simple and complex aneurysm to account for the large variations in physician work associated with different aneurysms. This resulted in four codes within this family:

61697 Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation
61698 Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation
61700 Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation
61702 Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation.

When these new codes were brought to the RUC it was difficult to predict the distribution of cases between the simple and complex codes making budget neutrality calculations impossible. Therefore the decision was made to value the simple and complex codes the same as the original base codes and collect volume data for several years prior to surveying and valuing the new codes.

Also at this time it was recognized that a potential rank order anomaly existed in this family of codes with the less complex carotid circulation aneurysms being valued greater than vertebrobasilar circulation aneurysms. In an effort to determine if this was in fact the case we surveyed the entire family of codes in the summer of 2004 when we needed to survey the new complex aneurysm codes, 61697 and 61698. What this preliminary survey data showed was that in addition to the rank order anomaly, the entire family of codes appeared to be undervalued because of significant underestimation of postoperative work in the 90 day global period in the original survey. Given that the changes to 61700 and 61702 were considered editorial, we could only have given the RUC recommendations on the new codes of 61697 and 61698 which would have created further anomalies in this family of codes with the potential of misvaluing the entire family of codes. Therefore we withdrew those codes form the RUC with the intention of bringing the entire family of codes to the five year review for survey.

This new survey data gives compelling evidence of previous misevaluation of this family of codes. The data confirms that there is a rank order anomaly between 61700 and 61702 under the current values.

Existing RVW 61700	50.44	Median Survey RVW 61700	52.0
Existing RVW 61702	48.34	Median Survey RVW 61702	60.0

An analysis of the IWPUT further shows little difference between the intraservice portion of the existing time data and the survey data. The primary difference is accounted for by changes in the postoperative work within the 90 day global period

Building Block Method	RVW
Proposed RVW	52.00

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	60	0.0224	1.34
Same day evaluation	30	0.0224	0.67
Scrub, prep	60	0.0081	0.49
Pre-service total			2.5

Post-service	Time	Intensity	
Immediate post	40	0.0224	0.90

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)	
ICU 99291	2.0	4.00	8.00	
99233	2.0	1.51		3.02
99232	3.0	1.06		3.18
99231	5.0	0.64	3.20	
Discharge 99238	1.0	1.28	1.28	
99215	0.0	1.73	0.00	

99214	1.0	1.08	1.08	
99213	2.0	0.65	1.30	
99212	0.0	0.43	0.00	
99211	0.0	0.17	0.00	
Post-service total			21.96	

Intra-serviceTime	240	IWPUT	0.115

Building Block Method		RVW	
Existing RVW		50.44	

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	60	0.0224	1.34
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.49
Pre-service total			2.26

Post-service	Time	Intensity	
Immediate post	45	0.0224	1.01

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
ICU 99291	1.0	4.00	4.00
99233	1	1.51	1.51
99232	2	1.06	2.12
99231	6	0.64	3.84
Discharge 99238	1.0	1.28	1.28
99215	0.0	1.73	0.00
99214	0.0	1.08	0.00
99213	4.0	0.65	2.60
99212	0.0	0.43	0.00
99211	0.0	0.17	0.00
Post-service total			16.36

Time	Intra-service	270	IWPUT	0.117

This additional work within the postoperative period may be accounted for by changing practice patterns. Over the past ten to fifteen years there has been a trend toward early surgery in the treatment of ruptured aneurysms. In the past, aneurysms, particularly of the vertebrobasilar circulation, would be treated in a delayed fashion after recovering from the subarachnoid hemorrhage. This resulted in shorter length of stay with more work in the pre-op non-global period. However, there has been increasing recognition that the risks of rehemorrhage outweighs the risks of early surgery in most patients so that now almost all patients are treated in the acute phase after their subarachnoid hemorrhage(SAH). Therefore the period of recovery from the SAH with the attendant risk of cerebral vasospasm now falls in the postop global period. We believe this explains the increased number and acuity of postoperative visits in the current survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
3. When microdissection utilizing the operating microscope is necessary, code 69990 would be reported as an add-on code.
4.
5. | CPT | Glob | Proposed RVW | Pre-time | Intra Time | Post-time |
6. | 61702 | 090 | 60 | 120 | 280 | 60 |
7. | 69990 | ZZZ | 3.47 | n/a* | | |
8. | Total | | 63.47 | | | |
9.
10. *69990 Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure) A specific intra-operative time is not associated with this code. Use of the operating microscope will add time and intensity to any operation, when employed

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 9% No 91%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 61700

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 4.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 2.0	
		99214: 1.0	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:61702 Global Period: 090

Recommended Work Relative Value
Specialty Society RVU: **60.00**
RUC RVU: **54.28**

CPT Descriptor: Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old woman has a sudden onset of severe headache with a brief period of unconsciousness. A CT scan shows diffuse subarachnoid hemorrhage in the basal cisterns and an angiogram shows a 0.8 cm aneurysm of the basilar artery. The patient undergoes a craniotomy for clipping of the intracranial aneurysm. Postoperative hospital care and office visits are conducted as necessary through the 90-day global.

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Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Pre-service includes: a review of the angiogram, imaging studies, appropriate lab studies; extensive informed consent with the patient and family; plus the day-of-service work of pre-op prep, scrub, positioning and equipment setup; and positioning is lengthy due to the use of a prone position and stabiliazation 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.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Frederick Boop					
Specialty(s):	Neurosurgery					
CPT Code:	61702					
Sample Size:	275	**Resp n:** 36		**Response:** 13.0 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		35.00	55.00	**54.28**	63.35	98.00

Pre-Service Evaluation Time:			**60.0**		
Pre-Service Positioning Time:			**40.0**		
Pre-Service Scrub, Dress, Wait Time:			**15.0**		
ntra-Service Time:	180.00	240.00	**280.00**	300.00	480.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**50.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**450.0**	99231x **5.0** 99232x **5.0** 99233x **5.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**84.0**	99211x **0.0** 12x **0.0** 13x **2.0** 14x **1.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
61682	090	61.48

CPT Descriptor Surgery of intracranial arteriovenous malformation; supratentorial, complex

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
47130	090	53.27

CPT Descriptor 1 Hepatectomy, resection of liver; total right lobectomy

MPC CPT Code 2	Global	Work RVU
20808	090	61.56

CPT Descriptor 2 Replantation, hand (includes hand through metacarpophalangeal joints), complete amputation

Other Reference CPT Code	Global	Work RVU
61686	090	64.39

CPT Descriptor Surgery of intracranial arteriovenous malformation; infratentorial, complex

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 30.5 %

TIME ESTIMATES (Median)

	CPT Code: 61702	**Key Reference CPT Code: 61682**
Median Pre-Service Time	115.00	120.00
Median Intra-Service Time	280.00	420.00
Median Immediate Post-service Time	50.00	50.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	450.0	182.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	84.0	46.00
Median Total Time	**1015.00**	**854.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.03	4.17
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	4.39
Urgency of medical decision making	4.69	3.69

Technical Skill/Physical Effort (Mean)

Technical skill required	4.86	4.83
Physical effort required	4.53	4.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.97	4.81
Outcome depends on the skill and judgment of physician	4.97	4.92
Estimated risk of malpractice suit with poor outcome	4.53	4.53

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.47	4.36
Intra-Service intensity/complexity	4.78	4.83
Post-Service intensity/complexity	4.56	4.25

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons have requested review of a family of four intracranial aneurysm codes during this five year review process. The two base codes in this family 61700 Surgery of intracranial aneurysm, intracranial approach; carotid circulation and 61702 Surgery of intracranial aneurysm, intracranial approach; vertebrobasilar circulation were originally surveyed by our society in 1995 as part of the first five year review of the RBRVS. Subsequently in 2001 these codes were changed and two new codes were added to better define the work associated with the operative repair of intracranial aneurysm. Each of the exisiting codes were

divided into a simple and complex aneurysm to account for the large variations in physician work associated with different aneurysms. This resulted in four codes within this family:

61697 Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation
61698 Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation
61700 Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation
61702 Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation.

When these new codes were brought to the RUC it was difficult to predict the distribution of cases between the simple and complex codes making budget neutrality calculations impossible. Therefore the decision was made to value the simple and complex codes the same as the original base codes and collect volume data for several years prior to surveying and valuing the new codes.

Also at this time it was recognized that a potential rank order anomaly existed in this family of codes with the less complex carotid circulation aneurysms being valued greater than vertebrobasilar circulation aneurysms. In an effort to determine if this was in fact the case we surveyed the entire family of codes in the summer of 2004 when we needed to survey the new complex aneurysm codes, 61697 and 61698. What this preliminary survey data showed was that in addition to the rank order anomaly, the entire family of codes appeared to be undervalued because of significant underestimation of postoperative work in the 90 day global period in the original survey. Given that the changes to 61700 and 61702 were considered editorial, we could only have given the RUC recommendations on the new codes of 61697 and 61698 which would have created further anomalies in this family of codes with the potential of misvaluing the entire family of codes. Therefore we withdrew those codes form the RUC with the intention of bringing the entire family of codes to the five year review for survey.

This new survey data gives compelling evidence of previous misevaluation of this family of codes. The data confirms that there is a rank order anomaly between 61700 and 61702 under the current values.

Existing RVW 61700	50.44	Median Survey RVW 61700	52.0
Existing RVW 61702	48.34	Median Survey RVW 61702	60.0

An analysis of the IWPUT further shows little difference between the intraservice portion of the existing time data and the survey data. The primary difference is accounted for by changes in the postoperative work within the 90 day global period

Building Block Method	RVW
Proposed RVW	60.00

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	90	0.0224	2.02
Same day evaluation	30	0.0224	0.67
Scrub, prep	60	0.0081	0.49
Pre-service total			3.17

Post-service	Time	Intensity	
Immediate post	60	0.0224	1.34

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)	
ICU 99291	1.0	4.00	4.00	
99233	4.0	1.51		6.04
99232	5.0	1.06		5.30
99231	5.0	0.64	3.20	
Discharge 99238	1.0	1.28	1.28	
99215	0.0	1.73	0.00	

99214	1.0	1.08	1.08	
99213	2.0	0.65	1.30	
99212	0.0	0.43	0.00	
99211	0.0	0.17	0.00	
Post-service total			23.54	

Intra-serviceTime	280	IWPUT	0.119

Building Block Method		RVW	
Existing RVW		48.34	

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	60	0.0224	2.02
Same day evaluation	30	0.0224	0.67
Scrub, prep	30	0.0081	0.49
Pre-service total			3.17

Post-service	Time	Intensity	
Immediate post	60	0.0224	1.34

Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
ICU 99291	1.0	4.00	4.00
99233	2	1.51	6.04
99232	3	1.06	5.30
99231	1	0.64	3.20
Discharge 99238	1.0	1.28	1.28
99215	0.0	1.73	0.00
99214	1.0	1.08	1.08
99213	2.0	0.65	1.30
99212	0.0	0.43	0.00
99211	0.0	0.17	0.00
Post-service total			23.54

Time	Intra-service	300	IWPUT	0.106

This additional work within the postoperative period may be accounted for by changing practice patterns. Over the past ten to fifteen years there has been a trend toward early surgery in the treatment of ruptured aneurysms. In the past, aneurysms, particularly of the vertebrobasilar circulation, would be treated in a delayed fashion after recovering from the subarachnoid hemorrhage. This resulted in shorter length of stay with more work in the pre-op non-global period. However, there has been increasing recognition that the risks of rehemorrhage outweighs the risks of early surgery in most patients so that now almost all patients are treated in the acute phase after their subarachnoid hemorrhage(SAH). Therefore the period of recovery from the SAH with the attendant risk of cerebral vasospasm now falls in the postop global period. We believe this explains the increased number and acuity of postoperative visits in the current survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.
3. When microdissection utilizing the operating microscope is necessary, code 69990 would be reported as an add-on code.
4.
5.
6.
7.
8.
9.
10.

CPT	Glob	Proposed RVW	Pre-time	Intra Time	Post-time
61702	090	60	120	280	60
69990	ZZZ	3.47	n/a*		
Total		63.47			

*69990 Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure) A specific intra-operative time is not associated with this code. Use of the operating microscope will add time and intensity to any operation, when employed

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 11% No 89%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 61702

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 2.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 2.0	
		99214: 1.0	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:63047 Global Period: 090 Specialty Society RVU: **14.08**

RUC RVU: **14.08**

CPT Descriptor: 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

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old women presents with five months of neurogenic claudication, unresponsive to physical therapy or epidural cortisone injections. Imaging studies reveal L4/5 spinal stenosis. She undergoes L4/5 decompressive laminectomy with medial facetectomies and bilateral L5 foraminotomies. Post-operative hospital care and office visits are conducted as necessary through the 90-day global period.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review pre-operative lab work-up; Write pre-operative orders for peri-operative medications; Locate, review, and place MRI and/or other spinal imaging studies on the view box in the operating room; Review planned incisions and procedure; Greet patient in holding area and review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family; Sign and mark operative site; Obtain informed consent; Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite; Review length and type of anesthesia with anesthesiologist; Monitor initial patient positioning for induction of anesthesia; Following the induction of anesthesia, assist with repositioning of patient; verify/assist with padding of the patient to prevent pressure on neurovascular structures; Scrub and gown; Mark the incisions and supervise prepping/draping of the patient

Description of Intra-Service Work: A midline incision is made in the skin and subcutaneous tissue. The L4 spinous process and lamina are exposed with subperiosteal dissection. The spinous process and lamina of L4 is removed with a drill or bone biting instruments. The ligamentum flavum is removed exposing the thecal sac and nerve roots. The medial L4-5 facets are removed with a drill or bone biting instruments exposing the L5 nerve roots. A foraminotomy is performed for the L5 nerve root. If a discectomy is performed to complete the foraminotomy, it is performed. The wound is irrigated and closed in layers (over a drain if placed). Sterile dressings are applied.

Description of Post-Service Work:

Hospital:

Turn patient into the supine position; When anesthesia is reversed, transfer to recovery room; Write an OP note in the patient's record; Examine patient, check wound(s) and patient progress, monitor for abnormal neurological findings; Sign OR forms, including pre- and postoperative diagnosis, operations performed; Discuss procedure outcome with family; Dictate postop report; Discuss procedure outcome with referring physician; Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company; Order and review films to check alignment of lumbar spine; Write orders daily, as necessary, for medications, diet, and patient activity; Examine patient daily, check wounds and patient progress; Review nursing/other staff patient chart notes; Chart patient progress notes; Discuss patient progress with referring physician (verbal and written); Answer patient/family questions, nursing/other staff questions (verbal and written), insurance staff questions; At discharge, review post-discharge wound care, use and proper fit of brace, and activity limitations, including planned physical therapy; Answer patient/family questions, nursing/other staff questions; Write orders for post-discharge films, and medications; Chart patient discharge notes

Office:

Write orders for medications and follow-up films; Review post-discharge films; Examine patient - perform periodic neurological exams; Monitor wounds and remove sutures/staples; Review use and proper fit of brace with patient; Review physical therapy progress and revise orders as needed; Dictate patient progress notes for medical chart; Answer patient/family questions, insurance staff questions; Discuss patient progress with referring physician (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	Charles Mick, MD; Robert Boop, MD; Chris Kauffman, MD					
Specialty(s):	NASS; AANS/CNS; AAOS					
CPT Code:	63047					
Sample Size:	1500	**Resp n:** 202		**Response:** 13.4 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	7.00	15.00	**14.08**	17.38	36.00	
Pre-Service Evaluation Time:			**60.0**			
Pre-Service Positioning Time:			**20.0**			
Pre-Service Scrub, Dress, Wait Time:			**15.0**			
Intra-Service Time:	30.00	60.00	**90.00**	120.00	480.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**30.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**30.0**	99231x **0.0** 99232x **1.0** 99233x **0.0**
Discharge Day Mgmt:	**36.0**	99238x **1.00** 99239x **0.00**
Office time/visit(s):	**69.0**	99211x **0.0** 12x **0.0** 13x **3.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
63050	090	20.75

CPT Descriptor Laminoplasty, cervical, with decompression of the spinal cord, two or more vertebral segments;

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
63030	090	11.98

CPT Descriptor 1 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)

MPC CPT Code 2	Global	Work RVU
22595	090	19.36

CPT Descriptor 2 Arthrodesis, posterior technique, atlas-axis (C1-C2)

Other Reference CPT Code	Global	Work RVU
63047	090	14.59

CPT Descriptor 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

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 202 **% of respondents:** 100.0 %

TIME ESTIMATES (Median)

	CPT Code: 63047	Key Reference CPT Code: 63050
Median Pre-Service Time	95.00	95.00
Median Intra-Service Time	90.00	150.00
Median Immediate Post-service Time	30.00	30.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	30.0	68.00
Median Discharge Day Management Time	36.0	36.00
Median Office Visit Time	69.0	61.00
Median Total Time	**350.00**	**440.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.55	3.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	4.03
Urgency of medical decision making	3.25	3.58

Technical Skill/Physical Effort (Mean)

Technical skill required	3.62	4.03
Physical effort required	3.48	3.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.87	3.99
Outcome depends on the skill and judgment of physician	3.92	4.18
Estimated risk of malpractice suit with poor outcome	4.33	4.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.41	3.72
Intra-Service intensity/complexity	3.31	3.75
Post-Service intensity/complexity	3.28	3.61

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
We recommend a RVW of 14.08, which represents a total decrease of .51 from the current RVW of 14.59.

We obtained this value by utilizing building block methodology (see attached tables). Our 202 respondents indicated a median RVW of 16.00. We modified this by either subtracting or adding the differences between each specific time category by comparing the current values from the RUC database to the median survey responses.

CPT Code:

	Current Values	Survey Values	Difference
Pre-service H&E	70	80	+10
Pre-service S&P	15	15	0
Intra-service	120	90	-30
Immediate Post	30	30	0
Post-Op visits			
99231	38	0	-38
99232	0	30	+30
99233			
99238	36	36	0
99239			
Post-Dis visits			
99211			
99212			
99213	69	69	0
99214			
99215			
Total RUC Time Change			-28
TOTAL RUC TIME	378	350	
IWPUT	.064	0.108	

Our median survey value of 16 results in an IWPUT of 0.108 which we thought was too high. Our 25% was 15 (IWPUT= 0.098) which we also thought was too high. Using our recommended RVW of 14.08 and our median survey times, , we computed an IWPUT for 63047 of 0.080.

We feel a IWPUT higher than the current value is justified by the additional data collected in our survey and based on past RUC precedent which has considered higher IWPUT in cases where the work is being performed in less time but with greater intensity and complexity. In our surveys (please see above), we asked respondents to indicate the degree to which intensity and complexity has changed in the past five years using the same 11 basic categories of work complexity and intensity used for standard RUC surveys. The question was on a 1-5 scale with 5 representing "a great deal more" and 1 representing "a great deal less" and 3 representing "no change". All 11 categories had a mean response greater than 3, indicating overall increases in complexity and intensity. Scoring particularly high were the last three questions assessing risk, skill and malpractice.

The recommended RVU is slightly less than the 25% survey median value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

63047 may be used alone or with a variety of other codes. Several scenarios are listed below

Typically Three Level decompression

	CPT	global	multi	RVW	Pre	Intra	Post	Total	
1.	63047	90	100%	14.08*	95	90	214	165	*proposed RVW
2.	63048	ZZZ	100%	3.26	0	51	0	51	
3.	63048	ZZZ	100%	3.26	0	51	0	51	
	TOTAL			20.60	95	192	214	167	

Typically One Level Decompression and fusion

	CPT	global	multi	RVW	Pre	Intra	Post	Total	
1.	22612	90	100%	22.58	95	150	214	459	
2.	63047	090	50%	7.04*		90		90	*proposed RVW
3.	TOTAL			29.62	95	240	214	549	

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 40% No 60%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 50% less complex (less work) 0% no change 50%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 50% no change 50%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 63047

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1.0	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:** 1.0	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213: 3.0	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:63048 Global Period: ZZZ Specialty Society RVU: **3.6**

RUC RVU: **3.55**

CPT Descriptor: Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old women presents with five months of neurogenic claudication, unresponsive to physical therapy or epidural cortisone injections. Imaging studies reveal L3/4 and L4/5 spinal stenosis. She undergoes L3/4 and L4/5 decompressive laminectomies, medial facetectomies and bilateral L4 and L5 foraminotomies. [NOTE – THIS IS AN ADD-ON CODE: For this survey only consider the physician work for the additional level laminectomy. The exposure, resection, and follow-up visits related to the first level laminectomy will be reported using the primary procedure code 63047, which has a 90-day global period.]

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: After completion of the first vertebral level treated, the physician proceeds to the next level. The incision and subperiosteal dissection is carried rostrally exposing the L3 spinous process and lamina. The spinous process and lamina of L3 is removed with a drill or bone biting instruments exposing the dura and ligamentum flavum of the L3-4 interspace. The ligamentum flavum is removed exposing the lateral recess of the spinal canal. Medial facetectomy (unilateral or bilateral) is performed with a drill, osteotome, or bone biting instruments. The L3 nerve root is exposed and decompressed via foraminotomy and discectomy (if necessary).

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005				
Presenter(s):	Charles Mick, MD; Robert Boop, MD; Chris Kauffman, MD				
Specialty(s):	NASS; AANS/CNS; AAOS				
CPT Code:	63048				
Sample Size:	1500	**Resp n:** 199	**Response:** 13.2 %		
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	3.00	3.55	**3.55**	6.00	18.00
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	15.00	30.00	**45.00**	45.00	120.00

CPT Code:

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
63048	ZZZ	3.26

CPT Descriptor Laminectomy, lumbar, each additional level

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
20937	ZZZ	2.79

CPT Descriptor 1 Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)

MPC CPT Code 2	Global	Work RVU
35600	ZZZ	4.94

CPT Descriptor 2 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)

	CPT Code: 63048	**Key Reference CPT Code: 63048**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	45.00	51.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**45.00**	**51.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.48	
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	
Urgency of medical decision making	3.20	

Technical Skill/Physical Effort (Mean)

Technical skill required	3.56	
Physical effort required	3.42	

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.64	
Outcome depends on the skill and judgment of physician	3.90	
Estimated risk of malpractice suit with poor outcome	4.34	

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.31	
Intra-Service intensity/complexity	3.30	
Post-Service intensity/complexity	3.25	

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Our surveys yielded a median intra-service time of 45 minutes. Applying the same IWPUT as 63047 of .080, we recommend a total RVW of 3.6.

We believe a higher IWPUT is justified by the additional data collected in our survey and because the work is being performed in less time but at greater intensity. Our median intraservice time indicates that we now complete this component of work in 45 minutes compared to the 51 minutes in the current RUC database. In our surveys (please see

above), we asked respondents to indicate the degree to which intensity and complexity has changed in the past five years using the same 11 basic categories of work complexity and intensity used for standard RUC surveys. The question was on a 1-5 scale with 5 representing "a great deal more" and 1 representing "a great deal less" and 3 representing "no change". All 11 categories had a mean response greater than 3, indicating overall increases in complexity and intensity. Scoring particularly high were the last three questions assessing risk, skill and malpractice.

In this case, the recommended RVU is almost exactly the same as the 25% survey median value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Typically Three Level decompression

	CPT	global	multi	RVW	Pre	Intra	Post	Total
1.	63047	90	100%	14.08	95	90	214	165
2.	63048	ZZZ	100%	3.26	0	51	0	51
3.	63048	ZZZ	100%	3.26	0	51	0	51
	TOTAL			20.60	95	192	214	167

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 50% No 50%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 40% less complex (less work) 0% no change 60%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 50% no change 50%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 63048

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/Specialty Society RVS Update Committee

Five-Year Review Recommendations

October 2005

Volume 2

AMA/Specialty Society RVS Update Committee
Five-Year Review Recommendations
October 2005

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AMA/Specialty Society RVS Update Committee Summary of All Codes in the Five-Year Review

CPT Code	*Work group*	*CPT Descriptor*	*2005 work rvu*	*Specialty Rec. work rvu*	*Action Key*	*WG Rec Work RVU*	*2004 Medicare utilization*
00797	4	Anesth, Surgery for Obesity	8.00	11.00	1	11.00	8,521
10060	HCPAC	Drainage of skin abscess	1.17	1.50	1	1.50	603,536
11040	HCPAC	Debride skin, partial	0.50	0.65	4	0.55	1,287,162
11041	HCPAC	Debride skin, full	0.82	0.80	3	0.80	738,321
11042	HCPAC	Debride skin/tissue	1.12	1.20	2	1.12	944,576
11100	1	Biopsy, skin lesion	0.81	1.00	2	0.81	1,981,129
11400	1	Exc tr-ext b9+marg 0 5<cm	0.85	1.13	2	0.85	58,652
11401	1	Exc tr-ext b9+marg 0.6-1cm	1 23	1 43	2	1 23	103,548
11402	1	Exc tr-ext b9+marg 1 1-2 cm	1.51	1 80	4	1 40	123,031
11403	1	Exc tr-ext b9+marg 2.1-3 cm	1 79	2.20	2	1.79	58,319
11404	1	Exc tr-ext b9+marg 3 1-4 cm	2 06	2.08	2	2.06	23,393
11406	1	Exc tr-ext b9+marg >4.0cm	2.76	3.80	4	3.20	23,256
11420	1	Exc h-f-nk-sp b9+marg 0.5<	0 98	1.50	2	0.98	37,395
11421	1	Exc h-f-nk-sp b9+marg 0 6-1	1.42	2.15	2	1.42	49,725
11422	1	Exc h-f-nk-sp b9+marg 1.1-2	1.63	2.25	2	1 63	51,753
11423	1	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.24	2	2.01	22,012
11424	1	Exc h-f-nk-sp b9+marg 3 1-4	2.43	2 61	2	2.43	7,718
11426	1	Exc h-f-nk-sp b9+marg >4.0 cm	3.77	3.78	2	3 77	5,430
11440	1	Exc face-mm b9+marg 0.5 < cm	1.06	1.65	4	1.00	71,485
11441	1	Exc face-mm b9+marg 0.6-1 cm	1.48	1.83	2	1.48	79,679
11442	1	Exc face-mm b9+marg 1 1-2 cm	1.72	2 00	2	1.72	61,434
11443	1	Exc face-mm b9+marg 2.1-3 cm	2 29	2.73	2	2.29	18,269
11444	1	Exc face-mm b9+marg 3.1-4 cm	3.14	3.30	2	3.14	5,200

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11446	1	Exc face-mm b9+marg >4 cm	4 48	4.50	2	4.48	2,738
11450	1	Removal, sweat gland lesion	2.73		7		702
11451	1	Removal, sweat gland lesion	3.94		7		243
11462	1	Removal, sweat gland lesion	2.51		7		398
11463	1	Removal, sweat gland lesion	3 94		7		130
11470	1	Removal, sweat gland lesion	3 25		7		428
11471	1	Removal, sweat gland lesion	4 40		7		168
11600	1	Exc tr-ext mlg+marg 0.5<cm	1 31	1.60	2	1.31	9,023
11601	1	Exc tr-ext mlg+marg 0.6-1cm	1.80	2.10	4	1.75	39,378
11602	1	Exc tr-ext mlg+marg 1.1-2cm	1.95	2 50	2	1.95	121,520
11603	1	Exc tr-ext mlg+marg 2.1-3<cm	2.19	3.42	4	2 50	61,629
11604	1	Exc tr-ext mlg+marg 3 1-4cm	2 40	3 80	4	2.85	24,581
11606	1	Exc tr-ext mlg+marg >4cm	3.42	5.25	4	4.70	22,555
11620	1	Exc h-f-nk-sp mlg+marg 0 5<	1 19	1 78	4	1.32	4,813
11621	1	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	2.13	2	1.76	21,521
11622	1	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.70	2	2 09	53,607
11623	1	Exc h-f-nk-sp mlg+marg 2 1-3	2.61	3 06	4	2.79	23,235
11624	1	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	3.48	4	3 30	8,418
11626	1	Exc h-f-nk-sp mlg+marg >4cm	4.29	4.90	2	4 29	7,033
11640	1	Exc face-mm malig+marg 0 5<	1.35	1 85	2	1.35	26,146
11641	1	Exc face-mm malig+marg 0.6-1	2.16	2.50	4	1.85	93,199
11642	1	Exc face-mm malig+marg 1.1-2	2.59	2 50	4	2.30	152,434
11643	1	Exc face-mm malig+marg 2.1-3	3.10	3 60	2	3.10	50,764
11644	1	Exc face-mm malig+marg 3.1-4	4.02	4.61	2	4.02	16,480
11646	1	Exc face-mm malig+marg>4	5.94	6.30	2	5.94	10,275
11730	HCPAC	Removal of nail plate	1.13	1.10	3	1 10	674,395

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11960	1	Insert tissue expander (s)	9.07		7		280
12052	1	Layer closure of wound(s)	2 77	3.20	2	2.77	73,449
13121	1	Repair of wound or lesion	4.32	4.56	2	4.32	47,763
14040	1	Skin tissue rearrangement	7.86	8.55	2	7.86	75,938
14060	1	Skin tissue rearrangement	8.49	9.10	2	8.49	89,343
15100	1	Skin split graft	9.04	9.00	2	9.04	21,432
15240	1	Skin full graft	9.03	9.40	2	9.03	11,260
15732	1	Muscle-skin graft, head/neck	17.81	18.25	5		10,101
15734	1	Muscle-skin graft, trunk	17.76	18.33	2	17.76	12,638
15831	1	Excise excessive skin tissue	12.38		5		1,649
17003	1	Destroy lesions, 2-14	0 15	0.55	4	0.07	14,967,497
17262	1	Destruction of skin lesions	1.58	1.70	2	1.58	155,455
17281	1	Destruction of skin lesions	1.72	1 80	2	1.72	149,754
17304	1	1 stage mohs, up to 5 spec	7.59	9 50	5		350,100
17305	1	2 stage mohs, up to 5 spec	2.85	6.00	5		187,597
19180	7	Removal of breast	8.79	15.25	4	14.67	15,560
19361	1	Breast reconstruction	19.23	24.00	7		486
20600	2	Drain/inject, joint/bursa	0.66	0 94	2	0 66	363,057
20610	2	Drain/inject, joint/bursa	0.79	1 80	2	0.79	4,532,254
20680	2	Removal of support implant	3 34	6 50	4	5 86	50,794
20692	2	Apply bone fixation device	6.40	15.00	5		1,526
21145	1	Reconstruct midface, lefort	19.91	23 50	4	21.84	12
21146	1	Reconstruct midface, lefort	20.68	27.50	4	22.55	2
21147	1	Reconstruct midface, lefort	21 74	28.13	4	23.32	3
21365	1	Treat cheek bone fracture	14.93		7		495
21366	1	Treat cheek bone fracture	17.74		7		12

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21395	1	Treat eye socket fracture	12.66	16 00	4	13.88	15
21432	1	Treat craniofacial fracture	8.60		7		9
21435	1	Treat craniofacial fracture	17.22		7		16
21436	1	Treat craniofacial fracture	28 00		7		2
21470	1	Treat lower jaw fracture	15.32	18.75	7		450
21556	2	Remove lesion neck/chest	5.56	15.50	5		5,923
21935	2	Remove tumor, back	17 93		7		1,333
22520	3	Percut vertebroplasty thor	8 90	8.90	2	8.90	13,992
22554	3	Neck spine fusion	18.59	16.40	3	16.40	24,477
22612	3	Lumbar spine fusion	20 97	22.58	4	22.00	43,306
22840	3	Insert spine fixation device	12.52	12.52	2	12.52	15,975
23076	2	Removal of shoulder lesion	7.62	15.00	5		2,053
23200	2	Removal of collar bone	12.06	24.00	5		31
23210	2	Removal of shoulder blade	12.47	28 00	5		42
23220	2	Partial removal of humerus	14.54	28.00	5		28
23515	2	Treat clavicle fracture	7.40		5		475
23585	2	Treat scapula fracture	8.95		5		281
23615	2	Treat humerus fracture	9 34		5		5,829
23616	2	Treat humerus fracture	21.24		5		3,447
23630	2	Treat humerus fracture	7 34		5		736
23670	2	Treat dislocation/fracture	7.89		5		170
23680	2	Treat dislocation/fracture	10.04		5		163
24076	2	Remove arm/elbow lesion	6.29	16.00	5		1,906
24077	2	Remove tumor of arm, elbow	11 74	22.00	5		779
24150	2	Extensive humerus surgery	13.25	30.00	5		60
24151	2	Extensive humerus surgery	15.56		7		3

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24152	2	Extensive radius surgery	10.04	25 00	5		4
24153	2	Extensive radius surgery	11.52		7		
24363	2	Replace elbow joint	18.46	21.00	4	21.07	1,013
24430	2	Repair of humerus	12 79	15.50	4	14 00	641
24545	2	Treat humerus fracture	10.44		5		1,067
24546	2	Treat humerus fracture	15 67		5		1,007
24575	2	Treat humerus fracture	10.64		5		139
24579	2	Treat humerus fracture	11.58		5		520
24635	2	Treat elbow fracture	13 17		5		550
24665	2	Treat radius fracture	8 13		5		594
24685	2	Treat ulnar fracture	8.79		5		5,596
25076	2	Removal forearm lesion deep	4.91	15.00	5		1,693
25077	2	Remove tumor, forearm/wrist	9.75	22.00	5		575
25170	2	Extensive forearm surgery	11 07	26.00	5		16
25447	2	Repair wrist joint(s)	10.35	10 35	2	10.35	8,991
25515	2	Treat fracture of radius	9.17		5		567
25526	2	Treat fracture of radius	12.96		5		133
25545	2	Treat fracture of ulna	8.89		5		1,011
25574	2	Treat fracture radius & ulna	7.00		5		301
25575	2	Treat fracture radius/ulna	10.43		5		1,106
25620	2	Treat fracture radius ulna	8 54		5		12,450
25628	2	Treat wrist bone fracture	8.42		5		182
26055	2	Incise finger tendon sheath	2 69	3 99	2	2.69	59,370
26160	2	Remove tendon sheath lesion	3 15	4.05	2	3.15	12,971
26600	2	Treat metacarpal fracture	1.96	2.40	1	2.40	16,336
26615	2	Treat metacarpal fracture	5.32		5		1,341

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26665	2	Treat thumb fracture	7.59		5		98
26685	2	Treat hand dislocation	6.97		5		73
26715	2	Treat knuckle dislocation	5.73		5		206
26735	2	Treat finger fracture, each	5.97		5		1,596
26746	2	Treat finger fracture, each	5 80		5		897
26765	2	Treat finger fracture, each	4 16		5		1,892
26785	2	Treat finger dislocation	4.20		5		520
26951	2	Amputation of finger/thumb	4.58	6 00	4	5.25	7,509
27048	2	Remove hip/pelvis lesion	6.24	18.00	5		1,032
27049	2	Remove tumor, hip/pelvis	13.64	28.00	5		510
27076	2	Extensive hip surgery	22.09	40 00	5		118
27078	2	Extensive hip surgery	13.42	35.00	5		59
27130	2	Total hip arthroplasty	20.09	20 09	2	20.09	106,878
27236	2	Treat thigh fracture	15.58	15 58	2	15.58	84,217
27248	2	Treat thigh fracture	10.43		5		1,433
27328	2	Removal of thigh lesion	5.56	17.00	5		1,953
27329	2	Remove tumor, thigh/knee	14 12	25 00	5		1,099
27365	2	Extensive leg surgery	16.25	30.00	5		350
27447	2	Total knee arthroplasty	21.45	21 45	2	21.45	246,836
27465	2	Shortening of thigh bone	13.85	17.50	1	17.50	26
27470	2	Repair of thigh	16.05	16.05	2	16.05	612
27472	2	Repair/graft of thgh	17.69	19 82	5		560
27511	2	Treatment of thigh fracture	13.62		5		4,093
27513	2	Treatment of thigh fracture	17.89		5		2,477
27514	2	Treatment of thigh fracture	17.27		5		1,246
27519	2	Treat thigh fx growth plate	15 00		5		19

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27535	2	Treat knee fracture	11 48		5		2,549
27540	2	Treat knee fracture	13.08		5		107
27556	2	Treat knee dislocation	14.39		5		74
27603	7	Drain lower leg lesion	4.93		7		5,106
27615	2	Removel tumor, lower leg	12.54	23.00	5		983
27619	2	Remove lower leg lesion	8.39	16.00	5		1,034
27645	2	Extensive lower leg surgery	14.15	30.00	5		62
27646	2	Extensive lower leg surgery	12.64	25.00	5		32
27647	2	Extensive ankle/heel surgery	12.22	20.00	5	20.00	159
27709	2	Incision of tibia and fibula	9.94	19.00	4	16.50	161
27720	2	Repair of tibia	11.77	18.50	5		564
27766	2	Treatment of ankle fracture	8 35		5		1,557
27784	2	Treatment of fibula fracture	7.10		5		321
27792	2	Treatment of ankle fracture	7.65		5		5,172
27814	2	Treatment of ankle fracture	10.66		5		11,719
27822	2	Treatment of ankle fracture	10.98		5		6,097
27826	2	Treat lower leg fracture	8.53		5		176
27827	2	Treat lower leg fracture	14 04		5		658
27828	2	Treat lower leg fracture	16 21		5		913
27829	2	Treat lower leg joint	5.48		5		1,693
27832	2	Treat lower leg dislocation	6.48		5		8
27880	7	Amputation of lower leg	11.83	13 75	1	13 75	20,589
28045	2	Excision of foot lesion	4.71	14.00	5		3,061
28415	2	Treat heel fracture	15.95		5		775
28445	2	Treat ankle fracture	15.60		5		265
28465	2	Treat mid foot fracture, each	7.00		5		275

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28485	2	Treat metatarsal fracture	5 70		5		1,858
28505	2	Treat big toe fracture	3.80		5		421
28525	2	Treat toe fracture	3.32		5		319
28555	2	Repair foot dislocation	6.29		5		138
28585	2	Repair foot dislocation	7.98		5		167
28615	2	Repair foot dislocation	7.76		5		677
28645	2	Repair toe dislocation	4.21		5		1,005
28675	2	Repair toe dislocation	2.92		5		149
28805	7	Amputation thru metatarsal	8.38	11.25	1	11.25	7,137
29075	2	Application of forearm cast	0.77	0.89	2	0.77	70,341
29580	HCPAC	Application of paste boot	0.57	0.60	1	0.60	446,399
30520	8	Repair of nasal septum	5.69	7 13	4	6 27	19,687
31225	8	Removal of upper jaw	19.20	24.00	1	24.00	802
31230	8	Removal of upper jaw	21 91	28 00	1	28 00	71
31255	8	Removal of ethmoid sinus	6.95		7		30,330
31360	8	Removal of larynx	17 05	28.00	1	28.00	668
31365	8	Removal of larynx	24.12	37.00	1	37.00	513
31367	8	Partial removal of larynx	21.83	28.00	4	27.36	74
31368	8	Partial removal of larynx	27.05	36.00	1	36.00	61
31370	8	Partial removal of larynx	21.35	25.00	1	25.00	69
31375	8	Partial removal of larynx	20 18	25.00	1	25.00	48
31380	8	Partial removal of larynx	20.18	25.00	1	25.00	28
31382	8	Partial removal of larynx	20 49	28 00	1	28 00	55
31390	8	Removal of larynx & pharynx	27.49	40.00	1	40.00	90
31395	8	Reconstruct larynx & pharynx	31.04	44.00	1	44.00	71
31575	8	Diagnostic laryngoscopy	1 10	1.53	2	1.10	500,946

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31579	8	Diagnostic laryngoscopy	2.26	2.54	2	2 26	24,241
31622	4	Dx bronchoscope/wash	2.78	2.80	2	2.78	100,186
32020	6	Insertion of chest tube	3 97		8		64,923
32095	6	Biopsy through chest wall	8.35		7		2,158
32141	6	Remove treat lung lesions	13 98	25 48	4	23.90	634
32442	6	Sleeve pneumonectomy	26.20	55.50	4	51.45	15
32445	6	Removal of lung	25.05	62 69	4	57.74	99
32484	6	Segmentectomy	20.66	25.27	4	23.25	1,320
32486	6	Sleeve lobectomy	23 88	43.94	4	39.44	120
32488	6	Complection pneumonectomy	25.67	40.97	4	38.95	179
32540	6	Removal of lung lesion	14 62	28 44	4	26.42	157
32651	6	Thoracoscopy, surgical	12.89	18 67	4	16.64	1,138
32652	6	Thoracoscopy, surgical	18.63	27.73	4	26.35	1,045
32653	6	Thoracoscopy, surgical	12.85	17.62	4	16.24	604
32654	6	Thoracoscopy, surgical	12 42	20.34	4	17.73	92
32655	6	Thoracoscopy, surgical	13 08	16 06	4	14 69	563
32657	6	Thoracoscopy, surgical	13.63	12.97	4	11.90	6,520
32662	6	Thoracoscopy, surgical	16 42	15.36	4	14.29	273
32663	6	Thoracoscopy, surgical	18.44	24.57	4	23.00	1,281
32665	6	Thoracoscopy, surgical	15.52	21.05	4	19.56	35
32815	6	Close bronchial fistula	23.12	46.99	4	42.94	174
33140	6	Heart vevascularize (lmr)	19.97	32.50	4	25.49	129
33141	6	Heart lmr w/other procedure	4.83	2.43	3	2.43	1,673
33208	4	Insertion of heart pacemaker	8.12	8 12	2	8.12	131,714
33300	6	Repair of heart wound	17.89	46.05	4	40.03	267
33305	6	Repair of heart wound	21 41	74.23	4	70 21	238

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33400	6	Repair of aortic valve	28.46	40.30	4	38.33	293
33405	6	Replacement of aortic valve	34 95	39 78	4	37.82	30,407
33406	6	Repacement of aortic valve	37.44	51.14	4	49 18	621
33410	6	Replacement of aortic valve	32.41	44.87	4	42 91	1,696
33411	6	Replacement of aortic valve	36.20	63.36	4	56.91	834
33413	6	Replacement of aortic valve	43.43	63.09	4	56.19	9
33414	6	Repair of aortic valve	30 30	40.00	4	36.52	62
33415	6	Revision, subvalvular tissue	27.11	37.00	4	34 58	100
33416	6	Revise ventricule muscle	30.30	37.00	4	34.25	536
33425	6	Repair of mitral valve	26.96	52 53	4	45.97	696
33426	6	Repair of mitral valve	32 95	41.86	4	39.78	7,622
33427	6	Repair of mitral valve	39.94	44.35	4	41.82	2,815
33430	6	Replacement of mitral valve	33.45	54 05	4	46.45	11,268
33460	6	Revision of tricuspid valve	23 56	50.75	4	40.19	66
33463	6	Valvuloplasty, tricuspid	25.58	57.01	4	50.93	885
33464	6	Valvuloplasty, tricuspid	27 29	44 85	4	40.30	2,446
33465	6	Replace tricuspid valve	28.75	51.80	4	45 72	337
33474	6	Revision of pulmonary valve	23 01	39 41	4	36 39	14
33475	6	Replacement, pulmonary valve	32.95	41.76	4	39.39	60
33505	6	Repair artery w/tunnel	26 80	36 00	1	36.00	5
33510	6	CABG, vein, single-vein single	28.96	36.49	4	31.75	7,775
33511	6	CABG, vein, two	29.96	39.96	4	35 22	8,165
33512	6	CABG, vein, three	31.75	46.55	4	40.26	8,168
33513	6	CABG, vein, four	31 95	47.94	4	41 65	3,873
33514	6	CABG, vein, five	32.70	50.65	4	44.36	1,103
33516	6	Cabg, vein, six or more	34.95	52 33	4	46 04	233

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
33517	6	CABG, artery	2.57	3.36	1	3 36	20,588
33518	6	CARG, artery-vein, two	4.84	7 41	1	7.41	46,283
33519	6	CARG, artery-vein, three	7.11	9 91	1	9.91	36,938
33521	6	CARG, artery-vein, four	9.39	12.01	1	12 01	12,106
33522	6	CARG, artery-vein, five	11.65	13.53	1	13.53	2,129
33523	6	Cabg, art-vein, six or more	13.93	15.39	1	15 39	399
33530	6	Coronary artery, bypass/reop	5.85	9.78	1	9.78	15,685
33533	6	CABG, arterial, single	29.96	32.66	4	30.85	113,651
33534	6	CABG, arterial, two	32.15	38 79	4	36 98	11,647
33535	6	CABG, arterial, three	34.45	43.66	4	41.85	2,937
33536	6	Cabg, arterial, four or more	37 44	47.34	4	45.53	1,119
33542	6	Removal of heart lesion	28.81	50.28	4	44 20	1,167
33545	6	Repair of heart demage	36.72	64.12	4	52 49	159
33641	6	Repair heart septum defect	21.36	28 52	4	27.71	2,330
'3665	6	Repair of heart defects	28.56	32.98	1	32.98	2
33684	6	Repair heart septum defect	29.61	32.50	1	32.50	3
33688	6	Repair heart septum defect	30.57	33.98	4	32.88	
33771	6	Repair great vessels defect	34.60	39.50	4	38.50	1
33779	6	Repair great vessels defect	36.16	42.00	4	41.00	
33781	6	Repair great vessels defect	36.40	42 00	4	41 00	1
33860	6	Ascending aortic graft	37.94	62.54	4	55.45	2,862
33863	6	Ascending aortic graft	44.93	61.85	4	55.10	1,815
33877	7	Thoracoabdominal graft	42.54	64.04	1	64.04	920
33945	6	Transplantation of heart	42.04	90.22	4	80.84	520
34001	7	Removal of artery clot	12.89	16.25	1	16 25	208
34201	7	Removal of artery clot	10.01	19.26	4	18.31	7,971

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
34471	7	Removal of vein clot	10 16	20.00	1	20.00	51
35081	7	Repair defect of artery	27.97	34.55	4	31.00	7,765
35102	7	Repair defect of artery	30 71	39.80	4	36 28	5,321
35216	7	Repair blood vessel lesion	18.72	33.57	4	34.00	286
35381	7	Rechanneling of artery	15.79		5		3,092
35501	7	Artery bypass graft	19.16		5		152
35506	7	Artery bypass graft	19.64	23.75	1	23.75	83
35507	7	Artery bypass graft	19.64		5		56
35508	7	Artery bypass graft	18.62	25.00	1	25.00	20
35509	7	Artery bypass graft	18 04		5		101
35515	7	Artery bypass graft	18.62	25 00	1	25 00	6
35516	7	Artery bypass graft	16.30	23.00	1	23.00	35
35541	7	Artery bypass graft	25.76		5		96
35546	7	Artery bypass graft	25.50		5		303
35556	7	Artery bypass graft	21.73	31.58	4	27.25	6,905
35566	7	Artery bypass graft	26.88	39 20	4	32.00	6,573
35583	7	Vein bypass graft	22.34	32.26	4	26.00	3,004
35585	7	Vein bypass graft	28.35	39.42	4	32.00	4,203
35600	6	Harvest artery for cabg	4.94		7		8,942
35601	7	Artery bypass graft	17.47		5		276
35606	7	Artery bypass graft	18.68	21 00	1	21 00	755
35612	7	Artery bypass graft	15.74		7		61
35616	7	Artery bypass graft	15 68	22 00	4	21.00	72
35641	7	Artery bypass graft	24.53		5		1,052
35642	7	Artery bypass graft	17.95		7		5
35820	6	Explore chest vessels	12.86	38.76	4	32.24	7,333

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37720	7	Removal of leg vein	5.65		5		3,764
38100	7	Removal of spleen, total	14.48	19.53	4	18.00	4,133
38101	7	Removal of spleen, partial	15.29	18 00	1	18.00	45
38115	7	Repair of ruptured spleem	15.80	20.00	1	20 00	245
38700	8	Removal of lymph nodes, neck	8.23	12 00	1	12.00	918
38720	8	Removal of lymph nodes, neck	13 59	20.00	1	20 00	960
38724	8	Removal of lymph nodes, neck	14.52	22.00	1	22.00	4,620
39220	6	Removal chest lesion	17 39	19.97	4	18.40	522
39400	6	Visualization of chest	5.60	7 61	1	7.61	14,114
41100	8	Biopsy of tongue	1.63	1.54	2	1.63	6,785
41120	8	Partial removal of tongue	9.76	10.00	2	9.76	1,537
41130	8	Partial removal of tongue	11.13	14.00	1	14.00	267
41135	8	Tongue and neck surgery	23.06	27.00	1	27.00	336
41140	8	Removal of tongue	25.46	25.00	2	25.46	23
41145	8	Tongue removal, neck surgery	30 01	34 00	1	34.00	51
41150	8	Tongue, mouth, jaw surgery	23 01	26.50	1	26 50	249
41153	8	Tongue, mouth, neck surgery	23 73	34.00	1	34.00	163
41155	8	Tongue, jaw, & neck surgery	27.68	40.00	1	40.00	548
42120	8	Remove plate/lesion	6 16	11.00	1	11.00	590
42842	8	Extensive surgery of throat	8.75	11 00	1	11 00	265
42844	8	Extensive surgery of throat	14.29	16.10	1	16.10	85
42845	8	Extensive surgery of throat	24.25	32.00	1	32 00	54
42890	8	Partial removal of pharynx	12.92	17.00	1	17.00	227
42892	8	Revision of pharyngeal walls	15.81	23.09	1	23 09	133
42894	8	Revision of pharyngeal walls	22.85	30.00	1	30 00	100
43108	6	Removal of esophagus	34 14	81.36	4	76.55	27

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
43113	6	Removal of esophagus	35.22	75.56	4	73.23	11
43116	6	Partial removal of esophaus	31.17	89.49	4	87.16	12
43118	6	Partial removal of esophaus	33.15	65.89	4	61.08	20
43121	6	Partial removal of esophaus	29.15	48.92	4	46.59	60
43123	6	Partial removal of esophaus	33.15	80.95	4	76 14	26
43124	6	Removal of esophagus	27.28	62 83	4	60.61	50
43135	6	Removal of esophagus pouch	16.08	25 66	4	24.20	132
43235	4	Uppr gi endoscopy, diagnosis	2 39	2.39	2	2 39	510,944
43246	4	Place gastrostomy tube	4.32	4 32	2	4.32	136,643
43496	1	Free jejunum flap, microvasc	0.00		7		24
43620	7	Removal of stomach	29.99	31 00	1	31 00	180
43621	7	Removal of stomach	30.68	39.62	4	36 00	767
43622	7	Removal of stomach	32 48	35.00	4	36.50	147
43632	7	Removal of stomach, partial	22.56	30.57	4	32.00	2,910
43633	7	Removal of stomach, partial	23.07	32 16	4	30.00	1,381
43634	7	Removal of stomach, partial	25.08	33.50	1	33.50	32
43750	4	Place gastrostomy tube	4.48	5 00	2	4.48	32,754
43820	7	Fusion of stomach and bowel	15.35	20.45	4	20.00	2,938
43840	7	Repair of stomach lesion	15.54	22.45	4	20.00	5,556
44120	7	Removal of small intenstive	16.97	23.43	4	20.11	30,806
44130	7	Bowel to bowel fusion	14.47	21 27	4	20.87	2,707
44140	7	Partial removal of colon	20 97	21 26	2	20.97	48,464
44143	7	Partial removal of colon	22.96	26 69	4	25.00	17,331
44150	7	Removal of colon	23.91	29 46	4	27.50	5,469
44151	7	Removal of colon/ileostomy	26.84	31 00	4	32.00	99
44152	7	Removal of colon/ileostomy	27.79		5		141

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
44153	7	Removal of colon/ileostomy	30.54		5		167
44155	7	Removal of colon/ileostomy	27.82	34.32	4	31.50	934
44156	7	Removal of colon/ileostomy	30.74	34.50	1	34.50	27
44602	7	Suture, small intestine	16.01	24.35	4	22 00	4,803
44603	7	Suture, small intestine	18.63	25.00	1	25 00	1,687
44604	7	Suture, large intestine	16 01		7		2,188
44605	7	Repair of bowel lesion	19.50		7		372
45020	7	Drainage of rectal abscess	4.71	7.75	1	7.75	637
45300	7	Proctosigmoidoscopy w/bx	0.38	0.92	4	0 91	57,539
45303	7	Proctosigmoidoscoy dilate	0.44	2 89	4	2.22	504
45305	7	Procosigmoidoscopy w/bx	1 01	2.68	4	2 01	2,219
45307	7	Proctosigmoidoscopy fb	0 94	2.89	4	2 22	151
45308	7	Proctosigmoidoscopy removal	0.83	2.68	4	2 01	280
45309	7	Proctosigmoidoscopy removal	2.01	2 89	4	2.22	229
45315	7	Proctosigmoidoscopy removal	1 40	2.89	4	2.22	110
45317	7	Proctosigmoidoscopy bleed	1.50	1.09	4	1 08	930
45320	7	Proctosigmoidoscopy ablate	1 58	3.10	4	2 43	207
45321	7	Proctosigmoidoscopy volvul	1.17	3 25	4	2.76	271
45327	7	Proctosigmoidoscopy w/stent	1 65	4.12	4	3.63	22
45330	4	Diagnostic sigmoidoscopy	0.96	1.10	2	0 96	122,925
45378	4	Diagnostic colonoscopy	3.69	3.69	2	3 69	1,143,087
46040	7	Incision of rectal abscess	4.95	4.95	2	4.95	5,767
46045	7	Incision of rectal abscess	4.31	5.50	1	5 50	338
46060	7	Incision of rectal abscess	5.68	5.68	2	5.68	1,104
46270	7	Removal of anal fistula	3.71	4.50	1	4 50	1,691
46275	7	Removal of anal fistula	4.55	5.00	1	5.00	1,218

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46280	7	Removal of anal fistula	5 97	5.97	2	5.97	1,519
46285	7	Removal of anal fistula	4.08	5 00	1	5.00	130
46600	7	Diagnostic anoscopy	0.50	0.58	4	0.49	95,217
46604	7	Anoscopy and dilation	1.31	1.09	4	1.08	1,511
46606	7	Anoscopy and biopsy	0.81	2.10	4	1.76	1,713
46608	7	Anoscopy, remove for body	1.51	2.43	4	1.95	110
46610	7	Anoscopy, remove lesion	1.32	2 65	4	1.95	284
46611	7	Anoscopy	1.81	1.09	4	1 08	176
46612	7	Anoscopy, remove lesions	2 34	2.81	4	2 14	106
46614	7	Anoscopy, control bleeding	2.01	1.09	4	1.08	1,737
46615	7	Anoscopy	2 68	1.20	4	1.18	322
46760	7	Repair of anal sphincter	14 41		7		36
46761	7	Repair of anal sphincter	13.82		7		273
46762	7	Implant artificial sphincter	12 69		7		28
47480	7	Incision of gallbladder	10.80		7		605
47490	7	Incision of gallbladder	7.22		7		3,857
47510	7	Insert catheter, bile duct	7.82		7		3,186
47511	7	Insert bile duct drain	10 48		7		5,491
47525	7	Change bile duct catheter	5.54		7		10,150
47530	7	Revise/reinsert bile tube	5.84		7		504
47562	7	Laparoscopic cholecystectomy	11.07	11 55	2	11.07	119,297
47600	7	Removal of gallbladder	13.56	17.62	4	15.88	29,510
47760	7	Fuse bile ducts and bowel	25.81	37.50	4	34.75	819
47765	7	Fuse liver ducts and bowel	24.84	48.50	1	48.50	43
47780	7	Fuse bile ducts and bowel	26.46	40.00	4	38 75	1,173
47785	7	Fuse bile ducts and bowel	31.13	51.00	4	52.50	306

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
49000	7	Exploration of abdomen	11 66		5		11,947
49002	7	Reopening of abdomen	10.47	22.35	4	15.75	4,599
49010	7	Exploration behind abdomen	12 26	16.00	4	15.00	1,646
49200	3	Removal of abdominal lesion	10.23		7		2,744
49201	3	Removal abdom lesion, complex	14.82		7		2,873
49505	7	Prp i/hern init reduc >5 yr	7.59	7 86	2	7.59	107,403
49906	1	Free omental flap, microvasc	0 00		7		3
50590	3	Fragmenting of kidney stone	9.08	10.34	2	9 08	52,828
51720	3	Treatment of bladder lesion	1.96	1 96	4	1.50	208,892
51798	3	Us urine capacity measure	0.00	0.38	1	0.38	1,174,387
52000	3	Cystoscopy	2.01	2.72	4	2 23	952,641
52204	3	Cystoscopy	2.37	3.08	4	2.59	39,733
52601	3	Prostatectomy (TURP)	12.35	15.50	4	14.00	70,777
53445	3	Insert uro/ves nck sphincter	14 04		7		1,834
54150	4	Circumcision	1.81		5		4
54152	4	Circumcision	2 31		5		310
54400	3	Insert semi-rigid prosthesis	8.98		7		444
54405	3	Insert multi-comp penis pros	13 41		7		4,133
54411	3	Remv/replc penis pros, comp	15.98		7		155
55700	3	Biopsy of prostate	1.57	2.83	4	2.58	233,082
56631	3	Extensive vulva surgery	16.18		7		257
56632	3	Extensive vulva surgery	20.26		7		219
56634	3	Extensive vulva surgery	17.85		7		77
56637	3	Extensive vulva surgery	21.94		7		239
56640	3	Extensive vulva surgery	22.14		7		18
57160	3	Insert pessary/other device	0.89	1.60	2	0.89	111,204

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
57240	3	Repair bladder & vagina	6.06	10.90	4	10.56	14,024
57250	3	Repair rectum & vagina	5.52	10 75	4	10.56	9,539
57260	3	Repair vagina	8 26	16.28	4	13.50	17,038
57265	3	Extensive repair of vagina	11.32	19 34	4	15 00	6,676
57288	3	Repair bladder defect	13.00	13.00	2	13 00	38,242
57500	3	Biopsy of cervix	0.97	1.35	4	1.20	9,266
57550	3	Removal of residual cervix	5.52		7		34
57555	3	Remove cervix/repair vagina	8.94		7		40
57556	3	Remove cervix, repair bowel	8 36		7		179
58120	3	Dilation and curettage	3.27	3.27	2	3 27	19,325
58150	3	Total hysterectomy	15 22	18.00	4	15.98	24,214
58260	3	Vaginal hysterectomy	12.96		7		9,651
58720	3	Removal of ovary/tube(s)	11.34	11.34	2	11 34	8,593
60600	7	Remove carotid body lesion	17.90	24.00	1	24.00	119
60605	7	Remove carotid body lesion	20 21	30.50	1	30.50	32
61154	3	Pierce skull & remove clot	14.97	14 97	2	14 97	8,547
61312	3	Open skull for drainage	24 53	27.00	1	27.00	9,350
61537	3	Removal of brain tissue	24.96	35.00	1	35.00	115
61538	3	Removal of brain tissue	26 77	38.00	1	38 00	109
61697	3	Brain aneurysm repr, complx	50.44	61.48	4	57.31	781
61698	3	Brain aneurysm repr, complx	48.34	65.00	4	64.03	60
61700	3	Brain aneurysm repr, simple	50.44	52.00	4	46.01	1,181
61702	3	Inner skull vessel surgery	48 34	60 00	4	54.28	44
62270	4	Spinal fluid tap, diagnostic	1 13	1.65	4	1 37	78,870
62350	3	Implant spinal canal cath	6.86		7		6,315
62351	3	Implant spinal canal cath	9.99		7		355

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62355	3	Removal spinal canal catheter	5.44		7		1,258
62360	3	Insert spine infusion device	2.62		7		443
62361	3	Implant spine infusion pump	5.41		7		231
62362	3	Implant spinal infusion pump	7.03		7		5,020
62365	3	Removal spine infusion device	5.41		7		1,155
63047	3	Removal of spinal lamina	14.59	14 08	3	14 08	75,647
63048	3	Remove spinal lamina add-on	3.26	3.60	4	3 55	118,656
63075	3	Neck spine disk surgery	19.38	18.58	3	18.58	19,930
63650	3	Implant neuroelectrodes	6.73		7		10,255
63655	3	Implant neuroelectrodes	10 27		7		1,306
63660	3	Revise/remove neuroelectrode	6 15		7		3,341
63685	3	Insrt/redo spine n generator	7.03		7		3,610
63688	3	Revise/remove neuroreceiver	5 38		7		2,658
64550	3	Apply neurostimulator	0.18		7		24,727
64553	3	Implant neuroelectrodes	2.31		7		60
64555	3	Implant neuroelectrodes	2.27		7		1,990
64560	3	Implant neuroelectrodes	2 36		7		7
64561	3	Implant neuroelectrodes	6.73		7		1,406
64565	3	Implant neuroelectrodes	1.76		7		964
64573	3	Implant neuroelectrodes	7 49		7		1,183
64575	3	Implant neuroelectrodes	4 34		7		209
64577	3	Implant neuroelectrodes	4.61		7		13
64580	3	Implant neuroelectrodes	4.11		7		27
64581	3	Implant neuroelectrodes	13.48		7		2,433
64585	3	Revise/remove neuroelectrode	2 06		7		1,078
64590	3	Insrt/redo perph n generator	2.40		7		2,005

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64595	3	Revise/remove neuroreceiver	1.73		7		579
64702	2	Revise finger/toe nerve	4 22	6 00	4	5.52	768
64721	2	Carpal tunnel surgery	4.28	5.00	2	4 28	114,443
65420	8	Removal of eye lesion	4.16	4.80	7		5,531
65426	8	Removal of eye lesion	5.24	6.58	4	5.85	4,706
65850	8	Incision of eye	10.50	11.93	4	11.14	338
65900	8	Remove eye lesion	10.91		7		100
66761	8	Revision of iris	4.06	4.06	2	4.06	85,708
66821	8	After cataract laser surgery	2.35	3.00	4	2 78	675,728
66984	8	Cataract surg w/iol, 1 stage	10.21	10.21	4	9.78	1,802,958
67038	8	Strip retinal membrane	21.21	21.21	5		52,260
67221	8	Ocular photodynamic ther	4.00	4.00	4	3.45	126,894
67228	8	Treatment of retinal lesion	12 72	12 72	5		110,068
67414	8	Explr/decompress eye socket	11 11	16.82	1	16 82	318
67445	8	Explr/decompress eye socket	14.40	18.00	1	18.00	222
67500	8	Inject/treat eye socket	0 79	1.44	1	1 44	16,121
67505	8	Inject/treat eye socket	0.82	1.27	1	1 27	1,210
67515	8	Inject/treat eye socket	0 61	1.40	1	1.40	35,076
67820	8	Revise eyelashes	0.89	0.71	3	0 71	285,124
67840	8	Remove eyelid lesion	2.04	2.04	2	2 04	49,843
67904	8	Repair eyelid defect	6.25	7.50	1	7.50	56,300
67911	8	Revise eyelid defect	5.26	7 30	1	7.30	2,790
67917	8	Repair eyelid defect	6.01		7		24,133
67924	8	Repair eyelid defect	5.78		7		11,210
67966	8	Revision of eyelid	6.56	8.50	1	8.50	5,926
68750	8	Create tear duct drain	8.65		7		873

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
68840	8	Explore/irrigate tear ducts	1.25	1.25	2	1 25	37,656
69210	8	Remove impacted ear wax	0.61	0.82	2	0.61	1,322,628
70355	4	Panoramic x-ray of jaws	0.20	0 22	2	0.20	28,678
71010	4	Chest x-ray	0.18	0.18	2	0 18	18,282,814
71020	4	Chest x-ray	0 22	0.22	2	0.22	15,676,163
71260	4	Ct thorax w/dye	1.24	1 30	2	1.24	1,971,811
72192	4	Ct pelvis w/o dye	1 09	1.11	2	1 09	1,222,624
72193	4	Ct pelvis w/dye	1.16	1.20	2	1.16	2,308,971
73100	4	X-ray exam of wrist	0.16	0.16	2	0.16	458,439
73110	4	X-ray exam of wrist	0.17	0.17	2	0 17	753,523
73120	4	X-ray exam of hand	0.16	0.16	2	0 16	296,490
73130	4	X-ray exam of hand	0.17	0 17	2	0 17	755,783
73140	4	X-ray exam of finger(s)	0.13	0 13	2	0.13	310,708
74000	4	X-ray exam of abdomen	0.18	0 18	2	0 18	1,838,163
'4020	4	X-ray exam of abdomen	0 27	0 27	2	0.27	994,189
74022	4	X-ray exam series, abdomen	0 32	0 32	2	0.32	1,089,991
74150	4	Ct abdomen w/o dye	1.19	1.23	2	1.19	1,315,665
74160	4	Ct abdomen w/dye	1.27	1.35	2	1.27	2,145,140
75552	4	Heart mri for morph w/o dye	1.60	2 23	5		1,205
75553	4	Heart mri for morph w dye	2.00	2 75	5		2,050
75554	4	Cardiac MRI/function	1.83	2 63	5		3,629
75555	4	Cardiac MRI/limited study	1.74	2 00	5		490
76075	4	Dxa bone density, axial	0.30	0.30	4	0.20	2,426,361
76519	8	Echo exam of eye	0.54	0.54	2	0.54	1,322,402
76700	4	Us exam, abdom, complete	0.81	0 81	2	0.81	1,329,410
76830	4	Transvaginal us, non-ob	0.69	0 69	2	0.69	325,124

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
77263	4	Radiation therapy planning	3 14	3.14	2	3 14	276,554
77280	4	Set radiation therapy field	0.70	0 70	2	0.70	240,934
77290	4	Set radiation therapy field	1.56	1.56	2	1.56	348,188
77300	4	Radiation therapy dose plan	0 62	0.62	2	0.62	1,282,101
77315	4	Teletx isodose plan complex	1.56	1 56	2	1.56	152,581
77331	4	Special radiation dosimetry	0 87	0.87	2	0.87	321,893
77334	4	Radiation treatment aid(s)	1.24	1 24	2	1 24	1,087,833
77470	4	Special radiation treatment	2.09	2.09	2	2 09	139,703
78306	4	Bone imaging, whole body	0.86	0.86	2	0 86	722,160
78315	4	Bone imaging, 3 phase	1.02	1 02	2	1.02	139,583
78465	4	Heart image (3d), multiple	1.46	1.46	2	1.46	2,930,407
78478	4	Heart wall motion add-on	0.62	0.62	4	0.50	2,765,566
78480	4	Heart function add-on	0.62	0 62	4	0 30	2,766,786
88309	4	Tissue exam by pathologist	2.28	3 00	4	2 80	200,175
88321	4	Microslide consultation	1.30	2 00	4	1 63	155,079
88323	4	Microslide consultation	1 35	2.31	4	1 83	34,714
88325	4	Comprehensive review of data	2.22	2 93	4	2.50	21,487
90465	4	Immune admin 1 inj, < 8 yrs	0 17		5		
90466	4	Immune admin addl inj, < 8 y	0.15		5		
90467	4	Immune admin o or n, < 8 yrs	0 00		5		
90468	4	Immune admin o/n, addl , < 8 y	0 00		5		
90473	4	Immune admin oral/nasal	0.00		7		
90474	4	Immune admin oral/nasal addl	0.00		7		
92083	8	Visual field examination(s)	0.50	0.60	2	0.50	2,434,073
92226	8	Special eye exam, subsequent	0.33	0 33	2	0 33	1,965,033
92235	8	Eye exam with photos	0.81	0.81	2	0 81	1,560,890

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
92250	8	Eye exam with photos	0.44	0.44	2	0.44	1,697,307
92506	8	Speech/hearing evaluation	0 86		7		11,395
92507	8	Speech/hearing therapy	0.52		7		18,376
92508	8	Speech/hearing therapy	0.26		7		711
92510	8	Rehab for ear implant	1.50		7		
92516	8	Facial nerve function test	0.43		7		419
92520	8	Laryngeal function studies	0 76		7		4,107
92526	8	Oral function therapy	0.55		7		4,962
92541	8	Spontaneous nystagmus test	0.40		7		143,644
92542	8	Positional nystagmus test	0 33		7		162,083
92543	8	Caloric vestibular test	0.10		7		445,808
92544	8	Optokinetic nystagmus test	0.26		7		134,220
92545	8	Oscillating tracking test	0.23		7		203,750
92546	8	Sinusoidal tracking test	0 29		7		182,055
92547	8	Supplemental electrical test	0 00		7		323,605
92548	8	Posturography	0 50		7		18,389
92551	8	Pure tone hearing test, air	0.00		7		1
92552	8	Pure tone audiometry, air	0 00		7		114,258
92553	8	Audiometry, air & bone	0 00		7		56,641
92555	8	Speech threshold audiometry	0.00		7		14,940
92556	8	Speech threshold, complete	0 00		7		30,566
92557	8	Comprehensive hearing test	0.00		7		1,024,287
92559	8	Group audiometric testing	0.00		7		
92560	8	Bekesy audiometry, screen	0 00		7		
92561	8	Bekesy audiometry, diagnosis	0.00		7		3,578
92562	8	Loudness balance test	0.00		7		3,465

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
92563	8	Tone decay hearing test	0.00		7		30,073
92564	8	Sisi hearing test	0.00		7		3,223
92565	8	Stenger test, pure tone	0.00		7		2,631
92567	8	Tympanometry	0.00		7		890,065
92568	8	Acoustic reflex testing	0 00		7		332,191
92569	8	Acoustic reflex decay test	0 00		7		61,234
92571	8	Filtered speech hearing test	0.00		7		1,735
92572	8	Staggered spondaic word test	0 00		7		141
92573	8	Lombard test	0 00		7		
92575	8	Sensorineural acuity test	0.00		7		893
92576	8	Synthetic sentence test	0.00		7		222
92579	8	Visual audiometry (vra)	0.00		7		1,041
92582	8	Conditioning play audiometry	0.00		7		916
92583	8	Select picture audiometry	0.00		7		293
92584	8	Electrocochleography	0.00		7		14,715
92585	8	Auditor evoke potent, compre	0 50		7		50,994
92586	8	Auditor evoke potent, limit	0.00		7		438
92587	8	Evoked auditory test	0 13		7		25,416
92588	8	Evoked auditory test	0.36		7		69,019
92596	8	Ear protector evaluation	0.00		7		55
92597	8	Oral speech device eval	0 86		7		1,856
92601	8	Cochlear implt f/up exam < 7	0.00		7		3
92602	8	Reprogram cochlear implt <7	0.00		7		3
92603	8	Cochlear implt f/up exam 7>	0.00		7		857
92604	8	Reprogram cochlear implt 7 >	0 00		7		6,923
92605	8	Eval for nonspeech device rx	0.00		7		

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92606	8	Non-speech device service	0.00		7		
92607	8	Ex for speech device rx, 1 hr	0.00		7		151
92608	8	Ex for speech device rx, addl	0 00		7		92
92609	8	Use of speech device service	0 00		7		159
92610	8	Evaluate swallowing function	0.00		7		3,313
92611	8	Motion fluoroscopy/swallow	0.00		7		3,543
92612	8	Endoscopy swallow tst (fees)	1.27		7		1,796
92614	8	Laryngoscopic sensory test	1 27		7		371
92616	8	Fees w/laryngeal sense test	1 88		7		1,857
92620	8	Auditory functon, 60 min	0.00		7		
92621	8	Auditory function, + 15 min	0.00		7		
92625	8	Tinnitus assessment	0.00		7		
93010	4	Electrocardiogram report	0 17	0.24	2	0.17	19,204,537
93015	4	Cardiovascular stress test	0.75	1.00	2	0.75	2,252,974
93018	4	Cardiovascular stress test	0 30	0.60	2	0.30	1,503,471
93325	4	Doppler color flow add-on	0 07	0.30	5		6,631,110
94010	4	Breathing capacity test	0.17	0.17	2	0.17	1,237,293
94657	4	Continued ventilator mgmt	0 83	1.37	5		309,199
95004	4	Percut allergy skin tests	0.00	0.03	5		11,262,370
95024	4	Id allergy test, drug/bug	0.00	0.04	5		3,417,111
95027	4	Id allergy titrate-airborne	0.00	0.03	5		349,204
95115	4	Immunotherapy, one injection	0.00	0.10	7		1,532,305
95117	4	Immunotherapy injections	0.00	0.10	7		1,728,170
95144	4	Antigen therapy services	0.06	0.12	2	0.06	303,805
95165	4	Antigen therapy services	0.06	0.12	2	0.06	6,017,763
95816	4	Eeg, awake and drowsy	1.08	1.08	2	1 08	228,893

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
95819	4	Eeg, awake and asleep	1.08	1 29	2	1.08	389,584
95861	4	Muscle test, 2 limbs	1.54	1 68	2	1.54	295,258
95872	4	Muscle test, one fiber	1.50	3.00	1	3.00	909
95900	4	Motor nerve conduction test	0.42	0.55	2	0 42	1,365,558
95904	4	Sense nerve conduction test	0.34	0.55	2	0 34	2,749,528
95925	4	Somatosensory testing	0.54	0.79	2	0.54	44,977
95926	4	Somatosensory testing	0.54	0 79	2	0.54	68,412
95927	4	Somatosensory testing	0.54	1 00	2	0 54	2,953
95953	4	EEG monitoring/computer	3.08	3.50	4	3.30	9,284
96105	HCPAC	Assessment of aphasia	0.00		7		519
96567	1	Photodynamic tx, skin	0.00	1.30	7		4,794
97802	HCPAC	Medical nutrition, indiv in	0.00		5		160,685
97803	HCPAC	Med nutrition, indiv, subseq	0.00		5		81,867
97804	HCPAC	Medical nutrition, group	0 00		5		6,406
99201	5	Office/outpatient visit, new	0 45	0.45	2	0.45	465,665
99202	5	Office/outpatient visit, new	0.88	0 88	2	0 88	2,742,495
99203	5	Office/outpatient visit, new	1.34	1.92	2	1 34	5,007,937
99204	5	Office/outpatient visit, new	2.00	2.78	4	2 30	3,201,161
99205	5	Office/outpatient visit, new	2.67	3 78	4	3 00	1,097,515
99211	5	Office/outpatient visit, est	0.17	0.17	2	0.17	10,445,542
99212	5	Office/outpatient visit, est	0.45	0.62	2	0.45	26,139,270
99213	5	Office/outpatient visit, est	0.67	1.40	6		111,261,211
99214	5	Office/outpatient visit, est	1.10	2.00	6		55,174,565
99215	5	Office/outpatient visit, est	1 77	2.70	6		6,953,937
99221	5	Initial hospital care	1.28	2.56	4	1.88	518,754
99222	5	Initial hospital care	2 14	3.43	4	2.56	3,486,006

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99223	5	Initial hospital care	2 99	4 26	4	3.78	5,721,509
99231	5	Subsequent hospital care	0.64	1.00	4	0 76	20,534,153
99232	5	Subsequent hospital care	1 06	2.02	4	1 30	50,336,836
99233	5	Subsequent hospital care	1.51	3.03	4	2 00	17,225,862
99238	5	Hospital discharge day	1.28	1 50	2	1 28	6,416,301
99239	5	Hospital discharge day	1.75	2.30	4	1.90	2,279,088
99241	5	Office consultation	0 64	1 00	2	0 64	456,792
99242	5	Office consultation	1.29	1.58	4	1.34	1,767,974
99243	5	Office consultation	1.72	2 01	4	1.88	4,897,411
99244	5	Office consultation	2.58	3.02	4	3 02	5,512,793
99245	5	Office consultation	3.42	4.00	4	3 77	2,122,524
99251	5	Initial inpatient consult	0 66	1 15	4	1 00	366,384
99252	5	Initial inpatient consult	1 32	1 81	4	1 50	1,157,331
99253	5	Initial inpatient consult	1.82	2 50	4	2 27	3,391,552
99254	5	Initial inpatient consult	2.64	3.50	4	3 29	5,626,795
99255	5	Initial inpatient consult	3.64	4.50	4	4 00	2,817,081
99281	5	Emergency dept visit	0 33	0.50	4	0.45	178,635
99282	5	Emergency dept visit	0.55	1.00	4	0.88	1,095,199
99283	5	Emergency dept visit	1.24	2.00	4	1 34	5,159,423
99284	5	Emergency dept visit	1.95	3 14	4	2 56	5,520,136
99285	5	Emergency dept visit	3.06	4.19	4	3 80	6,534,826
99291	5	Critical care, first hour	3.99	5.10	4	4.29	2,960,371
99292	5	Critical care, addl 30 min	2.00	2.66	4	2 15	340,790
99301	5	Nursing facility Care	1.20		5		288,654
99302	5	Nursing facility Care	1.61		5		583,581
99303	5	Nursing facility Care	2.01		5		1,219,830

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CPT Code	Work group	CPT Descriptor	2005 work rvu	Specialty Rec. work rvu	Action Key	WG Rec Work RVU	2004 Medicare utilization
99311	5	Nursing fac care, subseq	0.60		5		5,679,807
99312	5	Nursing fac care, subseq	1.00		5		9,791,724
99313	5	Nursing fac care, subseq	1.42		5		3,362,540
99321	5	Rest home visit, new patient	0.71		5		40,365
99322	5	Rest home visit, new patient	1.01		5		48,948
99323	5	Rest home visit, new patient	1 28		5		45,005
99331	5	Rest home visit, est patient	0.60		5		347,932
99332	5	Rest home visit, est patient	0.80		5		626,373
99333	5	Rest home visit, est patient	1.00		5		275,125
G0270	HCPAC	MNT subs tx for change dx	0.00		5		2,272
G0271	HCPAC	Group MNT 2 or more 30 mins	0 00		5		259

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2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99241	99242	99243	99244	99245	Total Time	2005 work RVU	RUC Rec Work RVU
00797	Anesth, surgery for obesity	8,521	4	N/A	1	30			185	30													245	8.00	11.00
11100	Biopsy, skin lesion	1,981,129	1	0	2	5			12	5													22	0.81	0.81
11400	Exc tr-ext b9+marg 0.5 < cm	58,652	1	10	2	5			10	5								1					35	0.85	0.85
11401	Exc tr-ext b9+marg 0.6-1 cm	103,548	1	10	2	10			20	5								1					50	1.23	1.23
11402	Exc tr-ext b9+marg 1.1-2 cm	123,031	1	10	4	10			25	5								1					55	1.51	1.40
11403	Exc tr-ext b9+marg 2.1-3 cm	58,319	1	10	2	10	5	5	30	10								1					75	1.79	1.79
11404	Exc tr-ext b9+marg 3.1-4 cm	23,393	1	10	2	10	5	5	40	10								1					85	2.06	2.06
11406	Exc tr-ext b9+marg > 4 0 cm	23,256	1	10	4	10	5	5	60	10									1				113	2.76	3 20
11420	Exc h-f-nk-sp b9+marg 0.5 <	37,395	1	10	2	5			10	5								1					35	0.98	0.98
11421	Exc h-f-nk-sp b9+marg 0.6-1	49,725	1	10	2	10			20	5								1					50	1.42	1.42
11422	Exc h-f-nk-sp b9+marg 1 1-2	51,753	1	10	2	10			25	5								1					55	1 63	1.63
11423	Exc h-f-nk-sp b9+marg 2.1-3	22,012	1	10	2	10	5	5	30	10								1					75	2.01	2.01
11424	Exc h-f-nk-sp b9+marg 3.1-4	7,718	1	10	2	10	5	5	40	10								1					85	2.43	2 43
11426	Exc h-f-nk-sp b9+marg > 4 cm	5,430	1	10	2	10	5	5	60	10									1				113	3.77	3 77
11440	Exc face-mm b9+marg 0.5 < cm	71,485	1	10	4	5			10	5								1					35	1.06	1 00
11441	Exc face-mm b9+marg 0 6-1 cm	79,679	1	10	2	10			20	5								1					50	1.48	1.48
11442	Exc face-mm b9+marg 1.1-2 cm	61,434	1	10	2	10			25	5								1					55	1 72	1.72
11443	Exc face-mm b9+marg 2 1-3 cm	18,269	1	10	2	10	5	5	30	10								1					75	2.29	2 29
11444	Exc face-mm b9+marg 3.1-4 cm	5,200	1	10	2	10	5	5	40	10								1					85	3.14	3 14
11446	Exc face-mm b9+marg > 4 cm	2,738	1	10	2	10	5	5	60	10									1				113	4 48	4.48
11600	Exc tr-ext mlg+marg 0.5 < cm	9,023	1	10	2	10			10	5									1				48	1.31	1 31
11601	Exc tr-ext mlg+marg 0.6-1 cm	39,378	1	10	4	15			20	5									1				63	1.80	1 75
11602	Exc tr-ext mlg+marg 1.1-2 cm	121,520	1	10	2	15			25	5									1				68	1.95	1.95
11603	Exc tr-ext mlg+marg 2.1-3 cm	61,629	1	10	4	20	5	5	30	10									1				93	2.19	2.50
11604	Exc tr-ext mlg+marg 3 1-4 cm	24,581	1	10	4	20	5	5	40	10									1				103	2.40	2.85
11606	Exc tr-ext mlg+marg > 4 cm	22,555	1	10	4	20	5	5	90	10									1				153	3.42	4.70
11620	Exc h-f-nk-sp mlg+marg 0.5 <	4,813	1	10	4	10			10	5									1				48	1 19	1.32
11621	Exc h-f-nk-sp mlg+marg 0.6-1	21,521	1	10	2	15			20	5									1				63	1.76	1.76
11622	Exc h-f-nk-sp mlg+marg 1 1-2	53,607	1	10	2	15			25	5									1				68	2.09	2.09
11623	Exc h-f-nk-sp mlg+marg 2 1-3	23,235	1	10	4	20	5	5	30	10									1				93	2.61	2 79
11624	Exc h-f-nk-sp mlg+marg 3 1-4	8,418	1	10	4	20	5	5	40	10									1				103	3 06	3.30
11626	Exc h-f-nk-sp mlg+mar > 4 cm	7,033	1	10	2	20	5	5	60	10									1				123	4.29	4.29
11640	Exc face-mm malig+marg 0.5 <	26,146	1	10	2	10			10	5									1				48	1.35	1.35
11641	Exc face-mm malig+marg 0.6-1	93,199	1	10	4	15			20	5									1				63	2.16	1 85
11642	Exc face-mm malig+marg 1.1-2	152,434	1	10	4	15			25	5									1				68	2 59	2.30
11643	Exc face-mm malig+marg 2.1-3	50,764	1	10	2	20	5	5	30	10									1				93	3.10	3 10
11644	Exc face-mm malig+marg 3.1-4	16,480	1	10	2	20	5	5	45	10									1				108	4.02	4.02
11646	Exc face-mm mlg+marg > 4 cm	10,275	1	10	2	20	5	5	65	10									1				128	5 94	5.94
12052	Layer closure of wound(s)	73,449	1	10	2	5			28	10								2					73	2.77	2 77
13121	Repair of wound or lesion	47,763	1	10	2	10			60	15								2					115	4.32	4.32
14040	Skin tissue rearrangement	75,938	1	90	2	15	10	5	90	25								2	2				221	7 86	7 86
14060	Skin tissue rearrangement	89,343	1	90	2	15	10	5	60	15								2	2				181	8.49	8.49
15100	Skin split graft	21,432	1	90	2	45	10	10	60	20			1		1			2	2				276	9.04	9.04
15240	Skin full graft	11,260	1	90	2	45	10	10	60	20					1			2	4				285	9.03	9.03
15734	Muscle-skin graft, trunk	12,638	1	90	2	30	15	15	163	30			1	1	1	1		2	2	1			493	17 76	17.76
17003	Destroy lesions, 2-14	14,967,497	1	ZZZ	4				2														2	0.15	0.07
17262	Destruction of skin lesions	155,455	1	10	2	5	3		15	5								1					43	1.58	1.58

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CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99241	99242	99243	99244	99245	Total Time	2005 work RVU	RUC Rec Work RVU
17281	Destruction of skin lesions	149,754	1	10	2	5	3		14	5								1					42	1 72	1.72
19180	Removal of breast	15,560	7	90	4	30	15	15	90	20			1		1				2	1			309	8.79	14.67
20600	Drain/inject, joint/bursa	363,057	2	0	2	10	2	2	5	5													24	0.66	0.66
20610	Drain/inject, joint/bursa	4,532,254	2	0	2	7			15	7													29	0.79	0.79
20680	Removal of support implant	50,794	2	90	4	35	15	15	50	15					0 5			2					178	3.34	5.86
21145	Reconstruct midface, lefort	12	1	90	4	43			202	64			2		1				6				511.5	19.91	21.84
21146	Reconstruct midface, lefort	2	1	90	4	46			227	67			2		1				6 5				563.5	20.68	22.55
21147	Reconstruct midface, lefort	3	1	90	4	46			252	67		1 5	3		1				6 5				692 5	21.74	23.32
21395	Treat eye socket fracture	15	1	90	4	30	15	15	120	30			1	1	1			1	1				333	12.66	13.88
22520	Percut vertebroplasty thor	13,992	3	10	2	30	15	15	45	30					0 5				1				176	8 90	8.90
22554	Neck spine fusion	24,477	3	90	3	60	20	15	90	30				1	1				3				350	18.59	16 40
22612	Lumbar spine fusion	43,306	3	90	4	60	20	15	150	30			1	2	1				3				459	20.97	22.00
22840	Insert spine fixation device	15,975	3	ZZZ	2				60														60	12.52	12.52
24363	Replace elbow joint	1,013	2	90	4	50	17.5	15	150	30			2	1	1			1	3				450.5	18.46	21.07
24430	Repair of humerus	641	2	90	4	30	18	15	102	15			2		1			1	3				338	12.79	14.00
25447	Repair wrist joint(s)	8,991	2	90	2	20	15	10	100	20					0 5			3	2				274	10.35	10.35
26055	Incise finger tendon sheath	59,370	2	90	2	20	15	5	20	20					0 5			2	1				151	2 69	2.69
26160	Remove tendon sheath lesion	12,971	2	90	2	20	15	5	20	20					0 5			2	1				151	3.15	3.15
26600	Treat metacarpal fracture	16,336	2	90	1	7	2	0	15	5								4					89	1.96	2 40
26951	Amputation of finger/thumb	7,509	2	90	4	20	15	5	30	20					0 5			3	2				199	4.58	5.25
27130	Total hip arthroplasty	106,878	2	90	2	60	15	15	135	30			3	1	1			1	3				462	20.09	20 09
27236	Treat thigh fracture	84,217	2	90	2	60	15	15	90	30			3	2	1			1	3				447	15 58	15.58
27447	Total knee arthroplasty	246,836	2	90	2	45	15	15	124	30			3	1	1			1	2	1			451	21.45	21.45
27465	Shortening of thigh bone	26	2	90	1	33	20	13	120	23			3		1			2	2				378	13 85	17.50
27470	Repair of thigh	612	2	90	2	30	10	15	120	20			2	1	1			4	1				382	16.05	16.05
27709	Incision of tibia & fibula	161	2	90	4	40	18	10	108	15			2		1			2	2				341	9.94	16.50
27880	Amputation of lower leg	20,589	7	90	1	30	15	15	80	20			5	1	1			1	2				382	11.83	13.75
28805	Amputation thru metatarsal	7,137	7	90	1	30	15	15	60	20			6		1			2	2				366	8.38	11.25
29075	Application of forearm cast	70,341	2	0	2	10	2	3	10														25	0.77	0.77
30520	Repair of nasal septum	19,687	8	90	4	13.5	10	15	60	15					0 5			2	2				207.5	5.69	6.27
31225	Removal of upper jaw	802	8	90	1	45	15	20	180	30			1	2	1	1 0		1	3	1			568	19.20	24 00
31230	Removal of upper jaw	71	8	90	1	60	15	20	225	30			2	2	1	1 0		1	3	1			647	21 91	28.00
31360	Removal of larynx	668	8	90	1	60	15	20	200	35			3	3	1	1 0		1	3	2			714	17.05	28 00
31365	Removal of larynx	513	8	90	1	60	15	20	300	40			4	3	1	1 0		1	3	2			838	24.12	37 00
31367	Partial removal of larynx	74	8	90	4	60	15	20	180	35			2	3	1	1 0		1	3	2			675	21.83	27.36
31368	Partial removal of larynx	61	8	90	1	60	15	20	285	40			3	3	1	1 0		1	3	2			804	27.05	36.00
31370	Partial removal of larynx	69	8	90	1	60	15	20	180	35			2	3	1	1 0		1	3	2			675	21.35	25.00
31375	Partial removal of larynx	48	8	90	1	60	15	20	150	35			2	3	1	1 0		1	3	2			645	20.18	25.00
31380	Partial removal of larynx	28	8	90	1	60	15	20	160	35			2	3	1	1 0		1	3	2			655	20.18	25.00
31382	Partial removal of larynx	55	8	90	1	60	15	20	180	35			2	3	1	1 0		1	3	2			675	20 49	28.00
31390	Removal of larynx & pharynx	90	8	90	1	60	15	20	360	40			3	3	2	1 0		1	3	2			920	27.49	40.00
31395	Reconstruct larynx & pharynx	71	8	90	1	60	15	20	400	40			4	3	2	1 0		1	3	2			979	31 04	44.00
31575	Diagnostic laryngoscopy	500,946	8	0	2	5	5	5	8	5													28	1.10	1.10
31579	Diagnostic laryngoscopy	24,241	8	0	2	10	5	0	15	15													45	2.26	2.26
31622	Dx bronchoscope/wash	100,186	4	0	2	10	5	5	30	15													65	2 78	2.78
32141	Remove/treat lung lesions	634	6	90	4	60	15	20	116	40			1	4	3	1		1	1				587	13 98	23.90
32442	Sleeve pneumonectomy	15	6	90	4	60	15	20	286	60			1	4	6	1			2				908	26.20	51 45

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CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99201	99202	99211	99212	99213	99214	99215	99217	99218	99219	99220	Total Time	2005 work RVU	RUC Rec Work RVU
32445	Removal of lung	99	6	90	4	60	15	20	310	40	1		1	4	6	1		1	1	2		1043	25 05	57.74
32484	Segmentectomy	1,320	6	90	4	60	15	20	139	40			1	2	2	1		1	1			509	20.66	23.25
32486	Sleeve lobectomy	120	6	90	4	60	15	20	240	40			1	3	4	1		1	1			722	23 88	39 44
32488	Completion pneumonectomy	179	6	90	4	60	15	20	194	40	1		1	2	4	1		1	1	1		747	25.67	38.95
32540	Removal of lung lesion	157	6	90	4	60	15	20	120	40			1	5	3	1		1	2			644	14.62	26 42
32651	Thoracoscopy, surgical	1,138	6	90	4	60	15	20	70	40			1	5		1		1	1			448	12.89	16 64
32652	Thoracoscopy, surgical	1,045	6	90	4	60	15	20	160	40			1	3	2	1		1	2			583	18 63	26.35
32653	Thoracoscopy, surgical	604	6	90	4	60	15	20	77	40			2	4		1		1	1			444	12.85	16 24
32654	Thoracoscopy, surgical	92	6	90	4	10	12	15	71	40			1	4	2	1		1	1			443	12.42	17.73
32655	Thoracoscopy, surgical	563	6	90	4	60	15	20	73	40			1	3		1		1	1			391	13.08	14.69
32657	Thoracoscopy, surgical	6,520	6	90	4	60	15	20	60	40				2		1		1	1			329	13.63	11.90
32662	Thoracoscopy, surgical	273	6	90	4	60	15	20	98	40				1		1		1	1			337	16.42	14.29
32663	Thoracoscopy, surgical	1,281	6	90	4	60	15	20	145	40			1	2	1	1		1	1			474	18 44	23.00
32665	Thoracoscopy, surgical	35	6	90	4	60	15	20	105	40			1	3	1	1		1	1			464	15 52	19.56
32815	Close bronchial fistula	174	6	90	4	60	15	20	155	40	1		1	7	6	1		1	1	2		978	23.12	42.94
33140	Heart revascularize (tmr)	129	6	90	4	60	15	20	113	40	1		1	1	3	1				1		557	19.97	25 49
33141	Heart tmr w/other procedure	1,673	6	ZZZ	3				19		0 11				0							30.03	4.83	2.43
33208	Insertion of heart pacemaker	131,714	4	90	2	15	15	15	60	30												135	8.12	8.12
33300	Repair of heart wound	267	6	90	4	10	12	15	144	40	3	1	1	2	4	1				1		759	17 89	40 03
33305	Repair of heart wound	238	6	90	4	10	12	15	296	40	6	2	1	2	4	1				1		1132	21 41	70.21
33400	Repair of aortic valve	293	6	90	4	60	15	20	211	40	1		1	1	3	1			1	1		678	28.46	38.33
33405	Replacement of aortic valve	30,407	6	90	4	60	15	20	198	40	1		1	2	3	1			1	1		695	34 95	37.82
33406	Replacement of aortic valve	621	6	90	4	60	15	20	282	40	1		1	2	3	1			1	1		779	37.44	49 18
33410	Replacement of aortic valve	1,696	6	90	4	60	15	20	229	40	1		1	2	3	1			1	1		726	32 41	42.91
33411	Replacement of aortic valve	834	6	90	4	60	15	20	283	40	2		1	4	4	1			1	1		944	36 20	56.91
33413	Replacement of aortic valve	9	6	90	4	60	15	20	297	40	2		1	1	3	1			1	1		827	43.43	56.19
33414	Repair of aortic valve	62	6	90	4	60	15	15	240	60	1		1	1	3	1				1		699	30 30	36.52
33415	Revision, subvalvular tissue	100	6	90	4	60	15	20	186	40	1		1	2	2	1				1		619	27 11	34.58
33416	Revise ventricle muscle	536	6	90	4	60	18	15	205	60	1		2	1	1	1			1	1		627	30 30	34.25
33425	Repair of mitral valve	696	6	90	4	60	15	20	254	40	1		1	2	4	1			1	1		792	26 96	45.97
33426	Repair of mitral valve	7,622	6	90	4	60	15	20	205	40	1		1	2	3	1			1	1		702	32 95	39 78
33427	Repair of mitral valve	2,815	6	90	4	60	15	20	221	40	1		1	2	2	1			1	1		677	39 94	41 82
33430	Replacement of mitral valve	11,268	6	90	4	60	15	20	223	40	2		1	2	3		1		2	1		815	33 45	46 45
33460	Revision of tricuspid valve	66	6	90	4	60	15	20	164	40	1		1	3	5	1				1		750	23 56	40.19
33463	Valvuloplasty, tricuspid	885	6	90	4	60	15	20	231	40	2		1	7	4	1			1	1		982	25.58	50.93
33464	Valvuloplasty, tricuspid	2,446	6	90	4	60	15	20	205	40	1		1	3	4	1			1	1		773	27.29	40.30
33465	Replace tricuspid valve	337	6	90	4	60	15	20	211	40	2		1	5	3	1			1	1		861	28.75	45 72
33474	Revision of pulmonary valve	14	6	90	4	60	15	20	222	40	1		1	2	2	1			1	1		678	23 01	36 39
33475	Replacement, pulmonary valve	60	6	90	4	60	15	20	234	40	1		1	2	2	1			1	1		690	32.95	39.39
33505	Repair artery w/tunnel	5	6	90	1	40	12	20	200	40	1		9		1	1			1			646	26.80	36.00
33510	CABG, vein, single	7,775	6	90	4	60	15	20	154	40	1		1	2	3	1		1		1		643	28 96	31.75
33511	CABG, vein, two	8,165	6	90	4	60	15	20	186	40	1		1	2	3	1		1		1		675	29.96	35.22
33512	CABG, vein, three	8,168	6	90	4	60	15	20	213	40	1		1	2	4	1		1		1		743	31.75	40.26
33513	CABG, vein, four	3,873	6	90	4	60	15	20	231	40	1		1	2	4	1		1		1		761	31.95	41 65
33514	CABG, vein, five	1,103	6	90	4	60	15	20	248	40	1		1	2	4	1		1		1		778	32.70	44.36
33516	Cabg, vein, six or more	233	6	90	4	60	15	20	264	40	1		1	2	4	1		1		1		794	34.95	46 04
33517	CABG, artery-vein, single	20,588	6	ZZZ	1				23		0 2				0							47 9	2.57	3.36

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CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99201	99202	99203	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
33518	CABG, artery-vein, two	46,283	6	ZZZ	1				50		0 36			1				100.6	4.84	7.41
33519	CABG, artery-vein, three	36,938	6	ZZZ	1				70		0 4			1				126.4	7.11	9 91
33521	CABG, artery-vein, four	12,106	6	ZZZ	1				88		0 38			1				144.3	9 39	12.01
33522	CABG, artery-vein, five	2,129	6	ZZZ	1				102		0 32			1				159 5	11 65	13.53
33523	Cabg, art-vein, six or more	399	6	ZZZ	1				110		0 4			1				176.2	13.93	15.39
33530	Coronary artery, bypass/reop	15,685	6	ZZZ	1				70		0 26			0				104 4	5.85	9.78
33533	CABG, arterial, single	113,651	6	90	4	60	15	20	151	40	1	1	1	3	1	1	1	610	29.96	30.85
33534	CABG, arterial, two	11,647	6	90	4	60	15	20	193	40	1	1	1	3	1	1	1	652	32 15	36 98
33535	CABG, arterial, three	2,937	6	90	4	60	15	20	231	40	1	1	1	3	1	1	1	690	34.45	41 85
33536	Cabg, arterial, four or more	1,119	6	90	4	60	15	20	259	40	1	1	1	3	1	1	1	718	37.44	45.53
33542	Removal of heart lesion	1,167	6	90	4	60	15	20	207	40	2	1	2	3	1	1	1	767	28.81	44 20
33545	Repair of heart damage	159	6	90	4	60	15	20	236	40	2	1	1	1	4	1	1	848	36 72	52.49
33641	Repair heart septum defect	2,330	6	90	4	60	15	20	164	40	1	1	1	1	1	1	1	526	21.36	27.71
33665	Repair of heart defects	2	6	90	1	60	15	15	200	60	1	1	1	1	1	1	1	577	28.56	32.98
33684	Repair heart septum defect	3	6	90	1	63	15	15	200	60	1	1	1	1	1	1	1	580	29.61	32 50
33688	Repair heart septum defect		6	90	4	60	15	15	235	40	1	1	1	1	1	1	1	592	30.57	32 88
33771	Repair great vessels defect	1	6	90	4	60	15	15	260	60	1	4	1	1	1	1	1	679	34.60	38.50
33779	Repair great vessels defect		6	90	4	60	15	15	280	40	1	4	1	1	1	1	1	694	36.16	41.00
33781	Repair great vessels defect	1	6	90	4	60	12	15	280	40	1	6	2		1	1	1	703	36.40	41 00
33860	Ascending aortic graft	2,862	6	90	4	45	15	20	305	40	2	1	2	3	1	1	1	850	37.94	55 45
33863	Ascending aortic graft	1,815	6	90	4	60	15	20	287	40	2	1	2	3	1	1	1	824	44.93	55 10
33877	Thoracoabdominal graft	920	7	90	1	50	45	15	324	60	3	1	2	3	1	2	1	1014	42 54	64.04
33945	Transplantation of heart	520	6	90	4	167	15	90	325	85	3	1	1	6	5	3	2	1556	42.04	80.84
34001	Removal of artery clot	208	7	90	1	30	15	15	90	30				3	1	2		352	12.89	16 25
34201	Removal of artery clot	7,971	7	90	4	30	15	15	128	30			2	2	1	2		398	10.01	18.31
34471	Removal of vein clot	51	7	90	1	30	15	15	180	20			3	1	1	2	1	436	10.16	20.00
35081	Repair defect of artery	7,765	7	90	4	60	15	15	210	30	1		2	3	1	1	1	633	27 97	31.00
35102	Repair defect of artery	5,321	7	90	4	60	15	15	265	30	1		2	3	1	1	1	688	30.71	36 28
35216	Repair blood vessel lesion	286	7	90	4	30	15	15	180	60	1		3	3	1	1	1	614	18 72	34.00
35506	Artery bypass graft	83	7	90	1	30	15	15	165	28			1	1	1	2		425	19.64	23.75
35508	Artery bypass graft	20	7	90	1	30	15	15	170	30			1	1	1	2		391	18.62	25.00
35515	Artery bypass graft	6	7	90	1	30	15	15	180	30			1	1	1	2		401	18.62	25.00
35516	Artery bypass graft	35	7	90	1	30	15	15	180	20			2	1	1	2		410	16.30	23.00
35556	Artery bypass graft	6,905	7	90	4	30	25	15	251	30			2	1	1	1	2	557	21 73	27.25
35566	Artery bypass graft	6,573	7	90	4	30	25	15	306	30			3	2	1	1	2	670	26.88	32.00
35583	Vein bypass graft	3,004	7	90	4	30	25	15	253	30			2	1	1	1	2	559	22.34	26.00
35585	Vein bypass graft	4,203	7	90	4	30	25	15	305	30			3	2	1	1	2	669	28.35	32.00
35606	Artery bypass graft	755	7	90	1	30	15	15	145	30				1	1	2		388	18.68	21.00
35616	Artery bypass graft	72	7	90	4	30	15	15	140	30			1	1	1	1	1	353	15.68	21.00
35820	Explore chest vessels	7,333	6	90	4	30	10	5	136	40	1		1	2	6	1	1	683	12 86	32.24
38100	Removal of spleen, total	4,133	7	90	4	30	15	15	120	30			3	1	1	1	1	412	14 48	18.00
38101	Removal of spleen, partial	45	7	90	1	30	15	15	120	30			3	1	1	1	1	412	15.29	18.00
38115	Repair of ruptured spleen	245	7	90	1	30	15	15	120	40			3	2	1	1	1	452	15.80	20.00
38700	Removal of lymph nodes, neck	918	8	90	1	30	15	15	90	30			1			1 0	1	296	8.23	12.00
38720	Removal of lymph nodes, neck	960	8	90	1	45	15	15	150	30			2	1		1 0	1	466	13.59	20 00
38724	Removal of lymph nodes, neck	4,620	8	90	1	45	15	15	180	30			2	1		1 0	1	496	14.52	22 00
39220	Removal chest lesion	522	6	90	4	60	15	20	124	40			1	2		1	1	412	17.39	18.40

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CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
39400	Visualization of chest	14,114	6	10	1	35	15	20	45	25			1			218	5.60	7.61
41100	Biopsy of tongue	6,785	8	10	2	10	10	5	15	10						65	1.63	1 63
41120	Partial removal of tongue	1,537	8	90	2	30	15	15	60	30						275	9.76	9.76
41130	Partial removal of tongue	267	8	90	1	45	15	20	90	30			3			400	11 13	14.00
41135	Tongue and neck surgery	336	8	90	1	60	15	20	210	30			2	2	1	655	23.06	27.00
41140	Removal of tongue	23	8	90	2	60	15	20	155	40			3	3	1	674	25 46	25.46
41145	Tongue removal, neck surgery	51	8	90	1	60	15	20	300	40			5	3	1	857	30.01	34.00
41150	Tongue, mouth, jaw surgery	249	8	90	1	60	15	20	180	40			3	2	1	669	23.01	26.50
41153	Tongue, mouth, neck surgery	163	8	90	1	60	15	20	270	40			3	3	1	774	23.73	34 00
41155	Tongue, jaw, & neck surgery	548	8	90	1	60	15	20	320	40			4	3	2	899	27.68	40 00
42120	Remove palate/lesion	590	8	90	1	30	15	15	80	30			1			301	6 16	11.00
42842	Extensive surgery of throat	265	8	90	1	30	15	15	80	30			1			324	8 75	11 00
42844	Extensive surgery of throat	85	8	90	1	45	15	15	120	30			2	1		428	14 29	16.10
42845	Extensive surgery of throat	54	8	90	1	60	15	20	240	40			4	3	2	758	24 25	32.00
42890	Partial removal of pharynx	227	8	90	1	45	15	20	120	30			3	2		482	12 92	17.00
42892	Revision of pharyngeal walls	133	8	90	1	45	15	20	170	35			3	2	1	601	15.81	23.09
42894	Revision of pharyngeal walls	100	8	90	1	60	15	20	240	40			3	4	1	774	22.85	30.00
43108	Removal of esophagus	27	6	90	4	60	15	20	461	40	1		1	6	5	1207	34 14	76.55
43113	Removal of esophagus	11	6	90	4	60	15	20	391	40	2		1	6	5	1200	35.22	73.23
43116	Partial removal of esophagus	12	6	90	4	60	15	20	561	40	1		1	6	4	1266	31.17	87.16
43118	Partial removal of esophagus	20	6	90	4	60	15	20	327	40	1		1	5	5	1043	33.15	61.08
43121	Partial removal of esophagus	60	6	90	4	60	15	20	240	40	1		1	3	4	855	29.15	46 59
43123	Partial removal of esophagus	26	6	90	4	60	15	20	442	40	1		1	8	5	1248	33.15	76.14
43124	Removal of esophagus	50	6	90	4	60	15	20	243	40	3		1	7	6	1209	27.28	60 61
43135	Removal of esophagus pouch	132	6	90	4	60	15	20	164	40			1	3	1	523	16.08	24.20
43235	Uppr gi endoscopy, diagnosis	510,944	4	0	2	18	5	5	20	15						63	2 39	2.39
43246	Place gastrostomy tube	136,643	4	0	2	35	8	5	38	20						106	4.32	4 32
43620	Removal of stomach	180	7	90	1	30	15	15	200	30	1		3	3	1	638	29.99	31 00
43621	Removal of stomach	767	7	90	4	30	15	15	240	30	1		3	3	2	719	30.68	36 00
43622	Removal of stomach	147	7	90	4	30	15	15	240	30	1		3	3	2	719	32.48	36.50
43632	Removal of stomach, partial	2,910	7	90	4	30	15	15	225	30			4	3	2	660	22.56	32.00
43633	Removal of stomach, partial	1,381	7	90	4	30	15	15	240	30			4	3	2	675	23.07	30 00
43634	Removal of stomach, partial	32	7	90	1	30	15	15	240	30			4	3	2	675	25 08	33.50
43750	Place gastrostomy tube	32,754	4	10	2	16	10	10	30	15			1			115	4.48	4.48
43820	Fusion of stomach and bowel	2,938	7	90	4	30	15	15	120	30			3	3	1	495	15.35	20 00
43840	Repair of stomach lesion	5,556	7	90	4	30	15	15	90	30	1		4	2	1	517	15.54	20 00
44120	Removal of small intestine	30,806	7	90	4	30	15	15	134	30			4	3	2	546	16.97	20.11
44130	Bowel to bowel fusion	2,707	7	90	4	30	15	15	131	30			5	1	1	484	14.47	20.87
44140	Partial removal of colon	48,464	7	90	2	30	15	15	150	30			5	1		462	20.97	20.97
44143	Partial removal of colon	17,331	7	90	4	30	15	15	150	30			3	2	2	551	22.96	25.00
44150	Removal of colon	5,469	7	90	4	30	15	15	180	30			3	3	1	585	23.91	27.50
44151	Removal of colon/ileostomy	99	7	90	4	30	15	15	240	30			5	3	1	683	26.84	32.00
44155	Removal of colon/ileostomy	934	7	90	4	30	15	15	240	30			5	3	1	683	27.82	31.50
44156	Removal of colon/ileostomy	27	7	90	1	30	15	15	300	30			5	3	1	743	30.74	34.50
44602	Suture, small intestine	4,803	7	90	4	30	15	15	90	30	1		3	3	1	505	16 01	22.00
44603	Suture, small intestine	1,687	7	90	1	30	15	15	120	30	1		4	3	1	577	18.63	25.00
45020	Drainage of rectal abscess	637	7	90	1	30	15	15	45	30			1			251	4 71	7.75

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CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
45300	Proctosigmoidoscopy dx	57,539	7	0	4	10	5	1	10	10													36	0.38	0.91
45303	Proctosigmoidoscopy dilate	504	7	0	4	20	10	5	20	30													85	0 44	2.22
45305	Proctosigmoidoscopy w/bx	2,219	7	0	4	20	10	5	15	30													80	1 01	2.01
45307	Proctosigmoidoscopy fb	151	7	0	4	20	10	5	20	30													85	0.94	2.22
45308	Proctosigmoidoscopy removal	280	7	0	4	20	10	5	15	30													80	0.83	2.01
45309	Proctosigmoidoscopy removal	229	7	0	4	20	10	5	20	30													85	2.01	2.22
45315	Proctosigmoidoscopy removal	110	7	0	4	20	10	5	20	30													85	1.40	2 22
45317	Proctosigmoidoscopy bleed	930	7	0	4	10	5	1	15	10													41	1.50	1.08
45320	Proctosigmoidoscopy ablate	207	7	0	4	20	10	5	25	30													90	1.58	2.43
45321	Proctosigmoidoscopy volvul	271	7	0	4	20	10	5	30	30													95	1 17	2.76
45327	Proctosigmoidoscopy w/stent	22	7	0	4	20	10	5	45	30													110	1.65	3.63
45330	Diagnostic sigmoidoscopy	122,925	4	0	2	7			17	8													32	0.96	0 96
45378	Diagnostic colonoscopy	1,143,087	4	0	2	20	5	5	30	15													75	3 69	3.69
46040	Incision of rectal abscess	5,767	7	90	2	30	15	15	30	20					05			2	1				181	4.95	4 95
46045	Incision of rectal abscess	338	7	90	1	30	15	15	30	30					1			1	1				194	4 31	5.50
46060	Incision of rectal abscess	1,104	7	90	2	30	15	15	40	20					05			1	2				199	5.68	5.68
46270	Removal of anal fistula	1,691	7	90	1	30	15	15	15	20					05			2	1				166	3.71	4.50
46275	Removal of anal fistula	1,218	7	90	1	30	15	15	30	20					05			2	1				181	4.55	5.00
46280	Removal of anal fistula	1,519	7	90	2	30	15	15	45	20					05			2	1				196	5.97	5.97
46285	Removal of anal fistula	130	7	90	1	30	15	15	30	20					05			2	1				181	4.08	5.00
46600	Diagnostic anoscopy	95,217	7	0	4	5	2	1	7	5													20	0 50	0.49
46604	Anoscopy and dilation	1,511	7	0	4	10	5	1	15	10													41	1 31	1.08
46606	Anoscopy and biopsy	1,713	7	0	4	20	10	5	10	30													75	0 81	1 76
46608	Anoscopy, remove for body	110	7	0	4	20	10	5	15	30													80	1.51	1.95
46610	Anoscopy, remove lesion	284	7	0	4	20	10	5	15	30													80	1.32	1.95
46611	Anoscopy	176	7	0	4	10	5	1	15	10													41	1 81	1.08
46612	Anoscopy, remove lesions	106	7	0	4	20	10	5	20	30													85	2.34	2.14
46614	Anoscopy, control bleeding	1,737	7	0	4	5	5	1	15	15													41	2 01	1.08
46615	Anoscopy	322	7	0	4	10	5	1	18	10													44	2.68	1.18
47562	Laparoscopic cholecystectomy	119,297	7	90	2	30	15	15	80	25					05			1	2				244	11.07	11.07
47600	Removal of gallbladder	29,510	7	90	4	30	15	15	115	30			1	1	1			1	2				392	13.56	15 88
47760	Fuse bile ducts and bowel	819	7	90	4	45	15	15	195	45	1		3	2	2	1			2	1			697	25.81	34.75
47765	Fuse liver ducts & bowel	43	7	90	1	45	15	15	290	53	1		4	2	2	1			2	1			819	24.84	48 50
47780	Fuse bile ducts and bowel	1,173	7	90	4	45	15	15	240	40	1		3	2	2	1			2	1			737	26.46	38.75
47785	Fuse bile ducts and bowel	306	7	90	4	45	15	15	360	40	1		4	2	2	1			2	1			876	31 13	52.50
49002	Reopening of abdomen	4,599	7	90	4	30	15	15	75	30			3	2	1	1		1	1				397	10.47	15.75
49010	Exploration behind abdomen	1,646	7	90	4	30	15	15	90	30			3	1		1		1	1				341	12.26	15 00
49505	Prp i/hern init reduc >5 yr	107,403	7	90	2	20	15	15	70	20					05			1	1				196	7 59	7 59
50590	Fragmenting of kidney stone	52,828	3	90	2	35	15	13	60	30					05			1	2				232	9.08	9.08
51720	Treatment of bladder lesion	208,892	3	0	4	20	2	5	12	10													49	1 96	1.50
51798	Us urine capacity measure	1,174,387	3	XXX	1	5			4														9	0.00	0 38
52000	Cystoscopy	952,641	3	0	4	10	2	5	15	10													42	2.01	2.23
52204	Cystoscopy	39,733	3	0	4	10	2	5	25	12													54	2.37	2.59
52601	Prostatectomy (TURP)	70,777	3	90	4	35	10	15	75	40			2	1		1		1	2				340	12.35	14.00
55700	Biopsy of prostate	233,082	3	0	4	20	5	5	15	20													65	1.57	2.58
57160	Insert pessary/other device	111,204	3	0	2	10	5	5	15	5													40	0.89	0 89
57240	Repair bladder & vagina	14,024	3	90	4	45	5	10	60	30			2	1		1		1	1				292	6 06	10.56

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57250	Repair rectum & vagina	9,539	3	90	4	45	5	10	60	30			2	1		1		1		1			292	5 52	10.56
57260	Repair of vagina	17,038	3	90	4	45	5	10	90	30			2	1		1		1		1			322	8.26	13.50
57265	Extensive repair of vagina	6,676	3	90	4	45	5	10	120	30			2	1		1		1		1			352	11 32	15 00
57288	Repair bladder defect	38,242	3	90	2	35	10	15	60	40			1	1		1		1		2			306	13.00	13.00
57500	Biopsy of cervix	9,266	3	0	4	7	1	1	15	5													29	0.97	1.20
58120	Dilation and curettage	19,325	3	10	2	20	5	10	25	27						0 5				1			128	3.27	3.27
58150	Total hysterectomy	24,214	3	90	4	45	5	10	120	30			3	1		1				2			379	15.22	15 98
58720	Removal of ovary/tube(s)	8,593	3	90	2	37	5	10	90	30			1	1		1		1		1			295	11.34	11.34
60600	Remove carotid body lesion	119	7	90	1	45	15	15	180	30			1	1		1				2			416	17 90	24.00
60605	Remove carotid body lesion	32	7	90	1	45	15	15	240	36				1	1	1				2			504	20.21	30.50
61154	Pierce skull & remove clot	8,547	3	90	2	60	15	15	60	30			4	2		1				3			421	14 97	14.97
61312	Open skull for drainage	9,350	3	90	1	60	15	15	150	30			6	4	1	1				2			627	24.53	27.00
61537	Removal of brain tissue	115	3	90	1	60	20	20	265	45			4	1		1				2			598	24.96	35.00
61538	Removal of brain tissue	109	3	90	1	60	20	20	330	45			4	1		1				2			663	26.77	38.00
61697	Brain aneurysm repr, complx	781	3	90	4	60	30	15	300	50			5	6	5	1				2	1		1055	50.44	57 31
61698	Brain aneurysm repr, complx	60	3	90	4	60	40	15	360	50			5	6	4	1				2	1		1084	48.34	64.03
61700	Brain aneurysm repr, simple	1,181	3	90	4	60	30	15	240	40			5	3	4	1				2	1		854	50.44	46 01
61702	Inner skull vessel surgery	44	3	90	4	60	40	15	280	50			5	5	5	1				2	1		1015	48 34	54.28
62270	Spinal Fluid Tap, diagnostic	76,191	4	0	4	7			20	5													32	1.13	1.37
63047	Removal of spinal lamina	75,647	3	90	3	60	20	15	90	30				1		1				3			350	14.59	14 08
63048	Remove spinal lamina add-on	118,656	3	ZZZ	4				45														45	3.26	3.55
63075	Neck spine disk surgery	19,930	3	90	3	60	20	15	90	30				1		1				2			342	19.38	18.58
64702	Revise finger/toe nerve	768	2	90	4	20	15	10	50	20						0 5				2			209	4.22	5.52
64721	Carpal tunnel surgery	114,443	2	90	2	20	15	10	25	20						0 5				2			169	4 28	4 28
65426	Removal of eye lesion	4,706	8	90	4	5	5	10	47 5	12						0 5				4			157.5	5.24	5.85
65850	Incision of eye	338	8	90	4	15	10	12.5	60	17.5						1 0				5			226	10 50	11.14
66761	Revision of iris	85,708	8	90	2	10	5	1	10	10										3			105	4 06	4.06
66821	After cataract laser surgery	675,728	8	90	4	15			11	10										2			82	2.35	2.78
66984	Cataract surg w/iol, 1 stage	1,802,958	8	90	4	10	5	10	30	10						0 5				2			159	10 21	9.78
67221	Ocular photodynamic ther	126,894	8	0	4	10	0	0	15	5													30	4 00	3.45
67414	Explr/decompress eye socket	318	8	90	1	15	10	15	120	30				1		1 0				1	1	1	332	11.11	16.82
67445	Explr/decompress eye socket	222	8	90	1	15	15	15	120	30				1		1 0				1	1	1	337	14 40	18.00
67500	Inject/treat eye socket	16,121	8	0	1	5	5	5	5	5													25	0.79	1.44
67505	Inject/treat eye socket	1,210	8	0	1	10	5	5	10	5													35	0 82	1.27
67515	Inject/treat eye socket	35,076	8	0	1	6	5	0	5	5													21	0 61	1.40
67820	Revise eyelashes	285,124	8	0	3	5	2	1	5	2													15	0 89	0.71
67840	Remove eyelid lesion	49,843	8	10	2	5	5	5	15	10										1			55	2.04	2 04
67904	Repair eyelid defect	56,300	8	90	1	10	10	15	45	15						0 5				3	1		181	6 25	7.50
67911	Revise eyelid defect	2,790	8	90	1	10	10	15	50	15						0 5				4			178	5.26	7 30
67966	Revision of eyelid	5,926	8	90	1	10	10	15	60	15						0 5				3	1		196	6.56	8.50
68840	Explore/irrigate tear ducts	37,656	8	10	2	5	3	0	10	5										1			38	1.25	1.25
69210	Remove impacted ear wax	1,322,628	8	0	2	5	2	0	10	2													19	0.61	0.75
70355	Panoramic x-ray of jaws	28,678	4	XXX	2				5	1													6	0.20	0.20
71010	Chest x-ray	18,282,814	4	XXX	2	1			3	1													5	0.18	0.18
71020	Chest x-ray	15,676,163	4	XXX	2	1			3	1													5	0.22	0.22
71260	Ct thorax w/dye	1,971,811	4	XXX	2	3			15	5													23	1.24	1 24
72192	Ct pelvis w/o dye	1,222,624	4	XXX	2	3			10	5													18	1.09	1.09

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99211	99212	99213	99214	99215	Total Time	2005 work RVU	RUC Rec Work RVU
72193	Ct pelvis w/dye	2,308,971	4	XXX	2	3			10	5													18	1 16	1 16
73100	X-ray exam of wrist	458,439	4	XXX	2	1			3	1													5	0.16	0.16
73110	X-ray exam of wrist	753,523	4	XXX	2	1			3	1													5	0.17	0.17
73120	X-ray exam of hand	296,490	4	XXX	2	1			3	1													5	0.16	0 16
73130	X-ray exam of hand	755,783	4	XXX	2	1			3	1													5	0.17	0.17
73140	X-ray exam of finger(s)	310,708	4	XXX	2	1			2	1													4	0 13	0.13
74000	X-ray exam of abdomen	1,838,163	4	XXX	2	1			3	1													5	0.18	0.18
74020	X-ray exam of abdomen	994,189	4	XXX	2	1			3	1													5	0 27	0.27
74022	X-ray exam series, abdomen	1,089,991	4	XXX	2	1			5	1													7	0 32	0.32
74150	Ct abdomen w/o dye	1,315,665	4	XXX	2	3			12	5													20	1.19	1 19
74160	Ct abdomen w/dye	2,145,140	4	XXX	2	3			15	5													23	1 27	1.27
76075	Dxa bone density, axial	2,426,361	4	XXX	4	1			4	1													6	0 30	0.20
76519	Echo exam of eye	1,322,402	8	XXX	2	5	7	0	5	0													17	0.54	0.54
76700	Us exam, abdom, complete	1,329,410	4	XXX	2	3			10	4													17	0.81	0.81
76830	Transvaginal us, non-ob	325,124	4	XXX	2	3			12	5													20	0 69	0.69
77263	Radiation therapy planning	276,554	4	XXX	2				75														75	3.14	3.14
77280	Set radiation therapy field	240,934	4	XXX	2				23														23	0.70	0.70
77290	Set radiation therapy field	348,188	4	XXX	2				70														70	1.56	1.56
77300	Radiation therapy dose plan	1,282,101	4	XXX	2				15														15	0.62	0.62
77315	Teletx isodose plan complex	152,581	4	XXX	2				45														45	1.56	1 56
77331	Special radiation dosimetry	321,893	4	XXX	2				30														30	0 87	0.87
77334	Radiation treatment aid(s)	1,087,833	4	XXX	2				35														35	1.24	1.24
77470	Special radiation treatment	139,703	4	XXX	2				55														55	2.09	2.09
78306	Bone imaging, whole body	722,160	4	XXX	2	5			8	5													18	0.86	0.86
78315	Bone imaging, 3 phase	139,583	4	XXX	2	5			10	5													20	1.02	1.02
78465	Heart image (3d), multiple	2,930,407	4	XXX	2	5			20	5													30	1.46	1 46
78478	Heart wall motion add-on	2,765,566	4	XXX	4				10	1													11	0.62	0.50
78480	Heart function add-on	2,766,786	4	XXX	4				5	1													6	0.62	0 30
88309	Tissue exam by pathologist	200,175	4	XXX	4				90														90	2.28	2.80
88321	Microslide consultation	155,079	4	XXX	4				50														50	1 30	1.63
88323	Microslide consultation	34,714	4	XXX	4				56														56	1.35	1.83
88325	Comprehensive review of data	21,487	4	XXX	4				80														80	2.22	2 50
92083	Visual field examination(s)	2,434,073	8	XXX	2	3	0	0	10	0													13	0.50	0.50
92226	Special eye exam, subsequent	1,965,033	8	XXX	2	5	0	0	10	5													20	0 33	0.33
92235	Eye exam with photos	1,560,890	8	XXX	2				28														28	0 81	0.81
92250	Eye exam with photos	1,697,307	8	XXX	2	0	0	0	9	5													14	0.44	0 44
93010	Electrocardiogram report	19,204,537	4	XXX	2				5	2													7	0.17	0.17
93015	Cardiovascular stress test	2,252,974	4	XXX	2	2			15	4													21	0.75	0.75
93018	Cardiovascular stress test	1,503,471	4	XXX	2	2			5	5													12	0.30	0.30
94010	Breathing capacity test	1,237,293	4	XXX	2				5	2													7	0.17	0.17
95144	Antigen therapy services	303,805	4	0	2				3														3	0.06	0 06
95165	Antigen therapy services	6,017,763	4	0	2				3														3	0.06	0.06
95816	Eeg, awake and drowsy	228,893	4	XXX	2	5			15	10													30	1.08	1 08
95819	Eeg, awake and asleep	389,584	4	XXX	2	5			20	10													35	1.08	1.08
95861	Muscle test, 2 limbs	295,258	4	XXX	2	15			25	10													50	1.54	1 54
95872	Muscle test, one fiber	909	4	XXX	1	15			60	20													95	1.50	3 00
95900	Motor nerve conduction test	1,365,558	4	XXX	2	4			6	4													14	0 42	0.42

2005 Five Year Review Physician Time

CPT Code	Short Descriptor	2004 Medicare Utilization	Work-group	Global Period	Action Key	Pre-Evaluation Time	Pre-Positioning Time	Pre-Service Scrub, Dress, Wait Time	Intra-Service Time	Immediate Post Service Time	99291	99292	99231	99232	99233	99238	99239	99241	99242	99243	99244	99245	99251	99252	99253	99254	99255	99281	99282	99283	99284	99285	99291	99292	Total Time	2005 work RVU	RUC Rec Work RVU
95904	Sense nerve conduction test	2,749,528	4	XXX	2	4			5	3																									12	0.34	0 34
95925	Somatosensory testing	44,977	4	XXX	2	6.5			15	10																									31.5	0.54	0.54
95926	Somatosensory testing	68,412	4	XXX	2	6.5			15	10																									31 5	0 54	0 54
95927	Somatosensory testing	2,953	4	XXX	2	6 5			15	10																									31.5	0 54	0.54
95953	EEG monitoring/computer	9,284	4	XXX	4	10			60	15																									85	3.08	3 30
99201	Office/outpatient visit, new	465,665	5	XXX	2	3			10	5																									18	0.45	0 45
99202	Office/outpatient visit, new	2,742,495	5	XXX	2	5			15	5																									25	0.88	0.88
99203	Office/outpatient visit, new	5,007,937	5	XXX	2	5			25	10																									40	1.34	1.34
99204	Office/outpatient visit, new	3,201,161	5	XXX	4	5			40	12																									57	2 00	2.30
99205	Office/outpatient visit, new	1,097,515	5	XXX	4	10			50	15																									75	2.67	3.00
99211	Office/outpatient visit, est	10,445,542	5	XXX	2	0			5	3																									8	0.17	0.17
99212	Office/outpatient visit, est	26,139,270	5	XXX	2	3			10	5																									18	0.45	0 45
99221	Initial hospital care	518,754	5	XXX	4	10			30	13																									53	1.28	1 88
99222	Initial hospital care	3,486,006	5	XXX	4	15			40	20																									75	2.14	2 56
99223	Initial hospital care	5,721,509	5	XXX	4	20			55	25																									100	2.99	3 78
99231	Subsequent hospital care	20,534,153	5	XXX	4	5			15	5																									25	0 64	0 76
99232	Subsequent hospital care	50,336,836	5	XXX	4	10			20	10																									40	1.06	1.30
99233	Subsequent hospital care	17,225,862	5	XXX	4	10			25	15																									50	1.51	2 00
99238	Hospital discharge day	6,416,301	5	XXX	2	9			20	10																									39	1 28	1.28
99239	Hospital discharge day	2,279,088	5	XXX	4	10			30	15																									55	1.75	1.90
99241	Office consultation	456,792	5	XXX	2	5			15	5																									25	0 64	0.64
99242	Office consultation	1,767,974	5	XXX	4	5			25	10																									40	1.29	1.34
99243	Office consultation	4,897,411	5	XXX	4	10			35	10																									55	1 72	1.88
99244	Office consultation	5,512,793	5	XXX	4	10			45	15																									70	2 58	3.02
99245	Office consultation	2,122,524	5	XXX	4	15			60	20																									95	3.42	3.77
99251	Initial inpatient consult	366,384	5	XXX	4	5			20	5																									30	0 66	1.00
99252	Initial inpatient consult	1,157,331	5	XXX	4	5			35	10																									50	1.32	1 50
99253	Initial inpatient consult	3,391,552	5	XXX	4	10			40	15																									65	1 82	2.27
99254	Initial inpatient consult	5,626,795	5	XXX	4	15			50	20																									85	2.64	3.29
99255	Initial inpatient consult	2,817,081	5	XXX	4	20			60	25																									105	3 64	4.00
99281	Emergency dept visit	178,635	5	XXX	4	2			7	4																									13	0 33	0.45
99282	Emergency dept visit	1,095,199	5	XXX	4	3			10	5																									18	0 55	0.88
99283	Emergency dept visit	5,159,423	5	XXX	4	5			18	7																									30	1 24	1.34
99284	Emergency dept visit	5,520,136	5	XXX	4	5			25	10																									40	1.95	2 56
99285	Emergency dept visit	6,534,826	5	XXX	4	8			40	15																									63	3 06	3 80
99291	Critical care, first hour	2,960,371	5	XXX	4	15			40	20																									75	3.99	4.29
99292	Critical care, addl 30 min	340,790	5	ZZZ	4				30																										30	2.00	2.15

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Workgroup 4 – Radiology/Pathology/Other Misc. Services
Recommendations

Representatives from the following medical specialties made work relative value recommendations to the RUC during its 2005 Five Year Review: radiology, radiation oncology, nuclear medicine, cardiology, endoscopy, pathology, neurology, allergy, anesthesia, and pulmonary medicine.

American Dental Association and the American Association of Oral and Maxillofacial Surgeons
CMS requested the RUC to review code 70355 Orthopanogram (Work RVU = 0.20) because it had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information). AAOMS conducted a random survey of 1,400 physicians using the RUC survey methodology and presented the results to the RUC for review. The survey results indicated that the code was slightly undervalued at its current level due to the time the respondents estimated for the service.

The RUC did not support an increase in the existing value as it was agreed that the specialty had not presented compelling evidence that the physician work had not changed. In addition, the specialty and the RUC agreed that the physician time from the survey was typically less than the survey results indicated.

American Society for Therapeutic Radiology and Oncology
CMS requested the RUC to review the following Radiation Oncology codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 77263, 77280, 77290, 77300, 77315, 77331, 77334, and 77470. The American Society for Therapeutic Radiology and Oncology (ASTRO) conducted a RUC survey of approximately 900 physicians with at least 100 respondents for each code. The survey results indicated that the Work RVUs for each code should be maintained at their current level, and ASTRO recommended no change in the work RVU.

The RUC agreed with the survey results and supported the specialty society's recommendation to maintain the work RVUs. The RUC found no compelling evidence to change the Work RVUs. In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the service being provided. Physician time for these procedures is recommended to be either maintained or less than current Harvard physician time.

American College of Radiology, American Academy of Orthopaedic Surgeons, and the American College of Obstetricians and Gynecologists

CMS requested the RUC to review the following imaging codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 71010, 71020, 71260, 72192, 72193, 73100, 73110, 73120, 73130, 73140, 74000, 74020, 74022, 74150, 74160, 76075, 76700, and 76830. The American College of Radiology (ACR) conducted a RUC survey for codes 71010, 71020, 71260, 72192, 72193, 74000, 74020, 74022, 74150, 74160, 76075, and 76700. ACR and the American Academy of Orthopaedic Surgeons (AAOS) conducted RUC surveys of 369 physicians with 77 respondents for codes 73100, 73110, 73120, 73130, and 73140. ACR and American College of Obstetricians and Gynecologists (ACOG) conducted a RUC survey of 279 physicians with 143 respondents for code 76830. The survey results from each of the societies indicated that the Work RVUs for each code should be maintained or increased from their current level.

The RUC agreed with the survey results and supported the specialty society's recommendation where the recommendation was to maintain the work RVUs. In addition, the RUC found no compelling evidence to change the Work RVUs, for those codes where the specialty recommended an increase. In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the service being provided. Physician time for these procedures is recommended to be maintained, higher, or lower than current Harvard physician time.

American College of Cardiology and the American College of Radiology

The American College of Cardiology (ACC) and American College of Radiology (ACR) recommended four cardiac imaging codes (75552, 75553, 75554, and 75555) to be sent to CPT for revision so that they may reflect current practice patterns. According to ACC and ACR, the current descriptions are confusing to members as well as payers for the services. The RUC agreed with the specialty society recommendation and recommends the family of codes be reviewed by the CPT Editorial Panel.

American College of Cardiology, American College of Radiology, and the Society of Nuclear Medicine

CMS requested the RUC to review the following codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 33208, 78306, 78315, 78465, 78478, 78480, 93010, 93015, 93018, and 93325. The American College of Cardiology (ACC) conducted a RUC survey on code 33208 involving 300 physicians with a response rate of 42.

The Society of Nuclear Medicine (SNM) and American College of Radiology (ACR) conducted a RUC survey for codes 78306 and 78315, involving 488 physicians with a response rate of over 80. SNM, ACR, and ACC conducted a RUC survey for codes 78465, 78478, and 78480 involving 574 physicians with over 100 respondents. ACC conducted a RUC survey for codes 93010, 93015, 93018, and 93325, involving several physicians with varying degrees of respondents. The survey results and recommendations from each of the societies indicated that the Work RVUs for each code should be either maintained or decreased from their current level.

The RUC found no compelling evidence to change the work RVUs and agreed with the survey results and supported the specialty society's recommendation to maintain the work RVUs for codes 33208, 78306, 78315, 78465, and 78478. Code 78480 was found to be not in the correct rank order and therefore overvalued by the RUC. Codes 93010, 93015, and 93018 were reviewed and the RUC found no compelling evidence to change the Work RVUs for these codes. However, code 93325 was referred to CPT by the RUC to be bundled with 93307.

In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the typical service being provided. Physician time for these procedures was recommended to be maintained, higher, or lower than current Harvard or RUC physician time.

<u>American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, Society of Interventional Radiology, and the American College of Radiology</u>

CMS requested the RUC to review the following endoscopy codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 43235, 43246, 43750, 45330, and 45378. The American Gastroenterological Association (AGA) and the American Society for Gastrointestinal Endoscopy (ASGE) conducted a RUC survey on codes 43235, 43246,

45330, and 45378, involving 255 physicians with a response rate of over 60. The Society of Interventional Radiology (SIR) and the American College of Radiology (ACR) conducted a RUC survey on Code 43750 involving 398 physicians with a response rate of 57. The survey results and recommendations from each of the societies indicated that the Work RVUs for each code should be either maintained or increased from their current level.

The RUC agreed with the survey results and supported the specialty society's recommendation to maintain the work RVUs for codes 43235, 43246, 43750, 45330, and 45378. The RUC found no compelling evidence to change the Work RVUs. In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the typical service being provided. Physician time for these procedures was recommended to be maintained, or lower than current Harvard or RUC physician time.

American Academy of Pediatrics and the American Academy of Neurology

The American Academy of Pediatrics (AAP) brought forth nine codes for this Five Year Review, however eight were withdrawn by AAP after the 2006 Proposed Rule was made public. Code 62270 remained and was jointly requested for review by AAP and the American Academy of Neurology (AAN) as it had never been through the RUC for the consideration of physician work. AAP and AAN conducted a survey of panel of 53 physicians with 31 responses. The survey results and recommendation from the specialties indicated that the Work RVU was undervalued, particularly so for the work associated with the young child population.

The RUC believed that there is a bimodal distribution of physician work associated with the code, whereas there are two different typical patient types, infant and young children. The RUC and the specialties believed that the infant population requires less work than in the young child population. The RUC suggested that it may be reasonable for the specialties to eventually consider splitting the code into the two typical patient types to capture any differences in physician work. With regard to the current 62270 code, however, the RUC recommended that it should be valued higher and recommended a work RVU of 1.35.

American Academy of Neurology, American Clinical Neurophysiology Society, American Association of Neuromuscular & Electrodiagnostic Medicine, and the American Academy of Physical Medicine and Rehabilitation

The American Academy of Neurology (AAN), American Clinical Neurophysiology Society (ACNS), American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), and the American Academy of Physical Medicine and Rehabilitation

(AAPMR) brought forth in different groups, the following five neurology and neuromuscular codes for this Five Year Review: 95872, 95925, 95926, 95927, and 95953. In addition, CMS requested the RUC to review the following neurological codes because they had

never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 95816, 95819, 95861, 95900, and 95904. The specialties surveyed hundreds of physicians for information on these codes and received over 30 respondents on most

of these services. The survey results and recommendations from the specialties indicated that the Work RVU was either currently correctly valued or undervalued.

The RUC agreed with the survey results and supported the specialty society's recommendation to maintain the work RVU for codes 95816 and the RUC found no compelling evidence to change the Work RVUs. Codes 95819, 95861, 95900, 95904, 95925, 95926, and 95927 were reviewed and the RUC found no compelling evidence to change the Work RVUs. However, codes 95872, and 95953 were found to have compelling evidence to increase the RVU above their existing values. In addition, the specialty and the RUC discussed the typical physician time for each code, and agreed that some of the surveyed times were too high for the typical service being provided. Physician time for three of these procedures was recommended to be lower than current Harvard or RUC physician time.

Joint Council of Allergy, Asthma, and Immunology and the American Academy of Otolaryngic Allergy

The Joint Council of Allergy, Asthma, and Immunology (JCAAI) and the American Academy of Otolaryngic Allergy (AAOA) brought forth the following five codes without work relative values for this Five Year Review based on their understanding that physician work was inherently in the service: 95004, 95024, 95027, 95115, and 95117. In addition, CMS requested the RUC to review the following neurological codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 95144 and 95165. The JCAAI and AAOA conducted surveys of 164 physicians and received at least 20 respondents for each code. The survey results and recommendations from the specialties indicated that the there was physician work in those codes currently with zero work values, and greater physician work for the codes were there currently is a work RVU.

The RUC reviewed the specialty society recommendations and survey results and referred the specialty to CPT Editorial Panel for clarification and possible revision at the CPT level for specific physician work codes for codes 95004, 95024, and 95027. The specialty withdrew codes 95115 and 95117 from consideration, and the RUC agreed that the current work RVUs were appropriate for codes

95144 and 95165, as there was no compelling evidence for a change. The RUC and the specialty agreed on physician time data for codes 95144 and 95165 to reflect the typical patient encounter.

College of American Pathologists

The College of American Pathologists brought forth the following four codes for review by the RUC during this Five Year Review because of changes in cancer protocols and the content of work: 88309, 88321, 88323, and 88325. The survey results and recommendation from the specialties indicated that the Work RVU was undervalued.

The RUC reviewed the specialty's survey results for each code and agreed with the specialty that they were undervalued for the increased physician work now involved in the service. The change in work was due to the increased number and type of slides undergoing review in the typical case, and in particular, the number of immunohistochemical slides that must undergo review. The RUC also believed that the clinical practice of these pathology consultations had changed based on recent literature. The RUC believed the specialty had presented compelling evidence to change the relative work value for each code. In addition, the RUC and specialty believed the 25th percentile survey results reflected the true physician work for each of the codes..

American Society of Anesthesiologists

The American Society of Anesthesiologists (ASA) requested that the RUC review code 00797 Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity. The specialty believed that the increased awareness of gastric restrictive procedures has led to an increased understanding of the intensity and complexity of the anesthesia management involved. The ASA conducted a survey of 94 physicians resulting in 40 respondents indicating the physician work was undervalued for this code.

The RUC reviewed the survey results and specialty society recommendation and agreed with their recommended median base unit value and physician time for the code.

American College of Chest Physicians and the American Thoracic Society

CMS requested the RUC to review the following pulmonary medicine codes because they had never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information): 31622, 94010, and 94657. The American College of Chest

Physicians (ACCP) and the American Thoracic Society (ATS) conducted a survey of 170 physicians resulting in at least 30 respondents for each code. The survey results and recommendations from the specialties indicated that the Work RVU was either currently correctly valued or undervalued.

The RUC reviewed the survey results and recommendations from the specialty for codes 31622, and 94010 and could not find a compelling reason to change the work RVUs for these codes. In addition, the RUC and the specialty agreed on typical physician time data elements from the survey results to reflect the typical patient encounter. The RUC did find compelling evidence to support the specialty society's recommendation and survey work value results for code 94657. The RUC discussed that a rank order anomaly would be created with code 94656, and therefore it should be reviewed at the February 2005 RUC meeting. In addition, the RUC and the specialty agreed on typical physician time data elements from the survey results to reflect the typical patient encounter for this code.

AMA/Specialty Society RVS Update Committee
RBRVS 2005 Five-Year Review
RUC Recommendations: Radiology/Pathology/Other Misc.

CPT Code	*Descriptor*	*2005 work RVU*	*RUC Rec Work RVU*	*Comment from the Public Comment Letter*	*RUC Rationale*	*Change in Time from 2005?*	*Action Key*
00797	ANESTH, SURGERY FOR OBESITY	8.00	11 00	ASA commented that the RUC fairly valued the service at the time of its presentation in April 2001 at 9 base units However, recent changes in the type and complexity of surgical procedures reported under this code and a more widespread awareness of the management issues associated with the care of the morbidly obese has likely changed the anesthesia work for the procedure since 2001. The increased awareness will lead to a more accurate assessment of the current physician work through the RUC process	The RUC reviewed the specialty's survey results and recommendation carefully, and agreed with the specialty that there was now a clear understanding of the physician work involved in this code When this code was originally valued, there had not been a widespread awareness of the management issues associated with the care of the morbidly obese. The increased awareness has led to a more accurate assessment of the current physician work. The RUC agreed with the survey data including all of the physician time elements. The RUC recommends a Base Unit Value of 11.00 for code 00797.	☑	1

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Action Key (1 = Adopt the recommended increase in the work RVU; 2 = Maintain the current work RVU; 3 = Adopt the recommended decrease in the work RVU; 4 = Suggest a new RVU; 5 = Refer the code to CPT; 6 = No consensus; 7 = Accept withdrawal by commenter, without prejudice; 8 = No Level of Interest submitted, no Recommendation submitted)

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
31622	DX BRONCHOSCOPE/WASH	2.78	2.78	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results and recommendation carefully, however the RUC found that there survey results did not support a change in the current RVU. The RUC and the specialty believe that the survey respondents overestimated the typical pre-service time and therefore lowered the overall pre-service time by 10 minutes from the survey results The RUC accepted the other The RUC recommends to maintain the current work value of 2 78 RVU. The RUC recommends a physician time data elements of: Pre-Service Evaluation of 10 minutes, Pre-Service Positioning of 5 minutes, Pre-Service Scrub Dress and Wait of 5 minutes, Intra-Service time of 30 minutes, and Immediate Post Time of 15 minutes, totaling 65 minutes	☑	2

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Action Key (1 = Adopt the recommended increase in the work RVU; 2 = Maintain the current work RVU, 3 = Adopt the recommended decrease in the work RVU; 4 = Suggest a new RVU; 5 = Refer the code to CPT; 6 = No consensus; 7 = Accept withdrawal by commenter, without prejudice; 8 = No Level of Interest submitted, no Recommendation submitted)

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
33208	INSERTION OF HEART PACEMAKER	8 12	8 12	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC agreed there had not been a change in the physician services that warranted a change the RVU for this service, and supported the specialty's recommendation to maintain the current value of 8.12 RVUs. In addition, the RUC and the specialty believed the typical procedure could not support the survey results for physician time in the pre-service time period The RUC and specialty believed that the total pre-service time was typically 45 minutes instead of 95 minutes from the survey The RUC recommends the work RVU be maintained at 8 12 RVUs and the pre-service time be altered from the survey results to be 45 minutes. The RUC recommends a physician time data elements of· Pre-Service Evaluation of 15 minutes, Pre-Service Positioning of 15 minutes, Pre-Service Scrub Dress and Wait of 15 minutes, Intra-Service time of 60 minutes, and Immediate Post Time of 30 minutes, totaling 135 minutes.	☑	2
43235	UPPR GI ENDOSCOPY, DIAGNOSIS	2.39	2 39	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results and recommendation carefully, and agreed with the specialty that there had not been a change in physician work The RUC agreed with the survey data including all of the physician time elements The RUC recommends a physician time data elements of· Pre-Service Evaluation of 18 minutes, Pre-Service Positioning of 5 minutes, Pre-Service Scrub Dress and Wait of 5 minutes, Intra-Service time of 20 minutes, and Immediate Post Time of 15 minutes, totaling 63 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
43246	PLACE GASTROSTOMY TUBE	4 32	4 32	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results and recommendation carefully, and agreed with the specialty that there had not been a change in physician work The RUC agreed with the specialty's survey data except for intra-service time, which was believed to be higher for the typical patient. The RUC then reviewed the work of recently reviewed code 43259 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum and/or jejunum as appropriate (Work RVU = 5.19), and believed the typical intra-service time of 43246 is approximately 38 minutes instead of the median survey time of 30 minutes. The RUC recommends a physician time data elements of· Pre-Service Evaluation of 35 minutes, Pre-Service Positioning of 8 minutes, Pre-Service Scrub Dress and Wait of 5 minutes, Intra-Service time of 38 minutes, and Immediate Post Time of 20 minutes, totaling 106 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
43750	PLACE GASTROSTOMY TUBE	4 48	4.48	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results and recommendation carefully, and agreed with the specialty that there had not been a change in physician work The RUC and specialty believed that the survey respondents overestimated the physician time for this procedure It was agreed that for the typical patient encounter, 16 minutes is more appropriate for pre-service evaluation and no discharge day management would be performed with this code since the vignette describes a patient with a different service. The RUC and specialty also recommend that code 43750 be placed on the conscious sedation list as it is an inherent part of the procedure. The RUC recommends that the Work RVU for code 43750 be maintained at 4 48 RVUs The RUC recommends a physician time data elements of Pre-Service Evaluation of 16 minutes, Pre-Service Positioning of 10 minutes, Pre-Service Scrub Dress and Wait of 10 minutes, Intra-Service time of 30 minutes, and Immediate Post Time of 15 minutes, one level 1 hospital stay and one level 2 office visit, totaling 115 minutes.	☑	2
45330	DIAGNOSTIC SIGMOIDOSCOPY	0.96	0 96	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC did not agree with the specialty to change the RVU for this service, and did not believe a slight increase, as suggested by the specialty, was warranted at this time. In addition, the RUC and specialty also believed that surveyed physician time for the service did not reflect the typical patient. The RUC believed that the current Harvard time of 17 minutes intra-service time and 32 minutes of total physician time was more typical and maintained the current time The RUC recommends to maintain the current value of 0 96 RVUs.	☐	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
45378	DIAGNOSTIC COLONOSCOPY	3.69	3.69	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the specialty's survey results and recommendation carefully, and agreed with the specialty that there had not been a change in physician work The RUC also reviewed codes 19103 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance (Work RVU = 3 69) and 19296 Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance, on date separate from partial mastectomy (Work RVU = 3.63) in relation to this code, and believed that changing the Work RVU would cause a rank order anomaly across specialties The RUC agreed with the physician time survey elements were appropriate and are recommended The RUC recommends a physician time data elements of. Pre-Service Evaluation of 20 minutes, Pre-Service Positioning of 5 minutes, Pre-Service Scrub Dress and Wait of 5 minutes, Intra-Service time of 30 minutes, and Immediate Post Time of 15 minutes, totaling 75 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
54150	CIRCUMCISION	1.81		AAP commented that this code has not been reviewed by the RUC for consideration of physician work. Additionally, in the last several years, the administration of regional anesthesia in the form of a penial or oral nerve block has become the standard of care for these types of circumcisions It is now typical for newborns to have such anesthesia, and AAP would like to incorporate the associated physician work and practice expense into the codes.	The American Academy of Pediatrics (AAP) requested the RUC consider referring the following codes to the CPT Editorial Panel for inclusion of anesthesia: 54150 Circumcision, using clamp or other device; newborn (Work RVU=1.81) and 54152 Circumcision, using clamp or other device; except newborn (Work RVU = 2 31), The RUC agreed with the specialty that these codes could be better handled through the CPT process, as the inclusion of the penile or orsal nerve block in the service changes the physician work involved.	☐	5
54152	CIRCUMCISION	2.31		AAP commented that this code has not been reviewed by the RUC for consideration of physician work Additionally, in the last several years, the administration of regional anesthesia in the form of a penial or oral nerve block has become the standard of care for these types of circumcisions. It is now typical for newborns to have such anesthesia, and AAP would like to incorporate the associated physician work and practice expense into the codes	The American Academy of Pediatrics (AAP) requested the RUC consider referring the following codes to the CPT Editorial Panel for inclusion of anesthesia 54150 Circumcision, using clamp or other device; newborn (Work RVU=1.81) and 54152 Circumcision, using clamp or other device; except newborn (Work RVU = 2 31), The RUC agreed with the specialty that these codes could be better handled through the CPT process, as the inclusion of the penile or orsal nerve block in the service changes the physician work involved	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
62270	SPINAL FLUID TAP, DIAGNOSTIC	1 13	1.37	AAP commented that this code has never been through the RUC for the consideration of physician work. This procedure is typically provided to children to rule out meningitis and involves a higher level of skill, effort, and risk compared to procedures with similar work RVUs For example, drainage of a simple abscess (10060) has a work value of 1.20 RVUs, the simple avulsion of a nail plate (11730) has 1 13 work RVUs; and the simple removal of a subcutaneous foreign body has a value for physician work of 1 22 RVUs. A lumbar puncture represents a significant difference in physician work from simpler procedures done typically in situations and on patients with less risk.	The RUC heard from specialty society representatives that 1) the code was not appropriately valued by Harvard, and 2) at least in the pediatric population, there has been an increased level of complexity in the typical patient. Current RVW for code 62270 Spinal puncture, lumbar, diagnostic = 1 13. The specialty believed that the patient-population had changed whereas the procedure is now more frequently performed on older children than in the past, apparently a more difficult cohort. The RUC noted that the Medicare utilization indicates the specialties that brought the code forward are infrequent providers of the service, but pediatrics provide a substantial number of these services outside the Medicare population. Medicare data indicates diagnostic radiology as the specialty most frequently billing this service but the American College of Radiology (ACR) although initially indicating a level 1 interest in the code changed to a level 2 interest. The ACR did later provide a comment letter supporting pediatrics' recommendation for an increase in the relative value. Specialty society representatives and RUC members discussed the survey results and the level of physician work, in relation to similar procedures and similar work RVUs to establish the correct level of physician work for this spinal procedure The RUC did believe that there had been an increase in the level of physician work for this service however had difficulty accepting the median and the 25th percentile of the specialty society's survey results. The RUC believed that the level of physician work for code 62270 should not exceed the work of code 62284 Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) (000 day global, work RVU 2005 = 1.54) In addition, the RUC and specialty society	☐	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
					believed that the physician work was closer to, but not equivalent to, code 27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid (000 day global, work rvu 2005 = 1.40; 10-25-5 minutes). The RUC recommends a relative work value of 1.35 for code 62270 since the intra-time of 62272 is 5-minutes less than the reference. With this recommendation, the specialty agreed that a rank order anomaly would not be generated with code 62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter) (000 day global, 2005 work rvu = 1 35) The physician time components were also discussed in light of the fact that an evaluation and management code is typically billed with 62270. The RUC recommends that the pre-service time be reduced from 25 minutes to 10 minutes. The RUC recommends the intra-service time of 20 minutes and immediate post time of 10 minutes from the specialty's survey results		

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
70355	PANORAMIC X-RAY OF JAWS	0.20	0.20	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results carefully, and found that the survey response rate to be low, and that the respondents may not have been thinking about the same service. The RUC believed the physician work had not changed, specifically for the subset of patients receiving this service reported as a medical CPT code rather than a dental D code, and therefore recommends to maintain the current value of 0.20 RVUs. The RUC and specialty however did discuss and agreed upon the typical physician time based on the survey results. The RUC recommends no pre-service time, 5 minutes of intra-service time, and 1 minute of immediate post service time for code 70355	☑	2
71010	CHEST X-RAY	0.18	0.18	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. However, the RUC and specialty believed that the post-service physician time typically was less than the 2 minutes as indicated by the survey respondents and therefore recommended 1 minute instead The RUC believed there should be no change the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.18 RVUs The RUC recommends a physician time data elements of Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
71020	CHEST X-RAY	0 22	0 22	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. However, the RUC and specialty believed that the pre and post-service physician time typically took less than 2 minutes as indicated by the survey respondents and therefore recommended 1 minute instead The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.22 RVUs The RUC recommends a physician time data elements of Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes.	☑	2
71260	CT THORAX W/DYE	1.24	1.24	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided However, the RUC and specialty believed that the pre-service physician time typically took less than 5 minutes as indicated by the survey respondents and therefore recommended 3 minutes instead The RUC believed there should be no change to the RVU for this service, and supported the specialty's recommendation to maintain the current value of 1 24 RVUs The RUC recommends physician time data elements of: Pre-Service Evaluation of 3 minutes, Intra-Service time of 15 minutes, and Immediate Post Time of 5 minutes, totaling 23 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
72192	CT PELVIS W/O DYE	1 09	1.09	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided The RUC believe there should be no change to the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.87 RVUs. The RUC recommends the specialty survey physician time data elements of: Pre-Service Evaluation of 3 minutes, Intra-Service time of 10 minutes, and Immediate Post Time of 5 minutes, totaling 18 minutes.	☑	2
72193	CT PELVIS W/DYE	1 16	1.16	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results and recommendation carefully, however the RUC believed that there was no change in physician work for this service and no change in the current RVU was warranted. The RUC recommends to maintain the current value of 1 16 RVUs. The RUC also recommends the specialty survey physician time data elements of· Pre-Service Evaluation of 3 minutes, Intra-Service time of 10 minutes, and Immediate Post Time of 5 minutes, totaling 18 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
73100	X-RAY EXAM OF WRIST	0.16	0 16	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.16 RVUs The RUC recommends the specialty survey physician time data elements of: Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes.	☑	2
73110	X-RAY EXAM OF WRIST	0.17	0 17	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.17 RVUs. The RUC recommends physician time data elements of: Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
73120	X-RAY EXAM OF HAND	0 16	0 16	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.16 RVUs. The RUC recommends physician time data elements of Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes	☑	2
73130	X-RAY EXAM OF HAND	0.17	0.17	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.17 RVUs. The RUC recommends physician time data elements of Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
73140	X-RAY EXAM OF FINGER(S)	0.13	0 13	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.13 RVUs The RUC recommends physician time data elements of· Pre-Service Evaluation of 1 minute, Intra-Service time of 2 minutes, and Immediate Post Time of 1 minute, totaling 4 minutes.	☑	2
74000	X-RAY EXAM OF ABDOMEN	0.18	0 18	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. However, the RUC and specialty believed that the post-service physician time typically took less than 2 minutes as indicated by the survey respondents and therefore recommended 1 minute instead In addition, the RUC believed this service was similar to 71010 Radiologic examination, chest, single view, frontal (0 18 RVUs). The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0 18 RVUs. The RUC recommends physician time data elements of· Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
74020	X-RAY EXAM OF ABDOMEN	0.27	0 27	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. However, the RUC and specialty believed that the pre and post-service physician time typically took less than 2 minutes as indicated by the survey respondents and therefore recommended 1 minute instead. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.27 RVUs. The RUC recommends physician time data elements of. Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes.	☑	2
74022	X-RAY EXAM SERIES, ABDOMEN	0.32	0 32	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. However, the RUC and specialty believed that the pre and post-service physician time typically took less than 2 minutes as indicated by the survey respondents and therefore recommended 1 minute instead. The RUC believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.32 RVUs. The RUC recommends physician time data elements of. Pre-Service Evaluation of 1 minute, Intra-Service time of 3 minutes, and Immediate Post Time of 1 minute, totaling 5 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
74150	CT ABDOMEN W/O DYE	1.19	1.19	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the specialty's survey results carefully, and found that there hadn't been a change in physician work to support a change in the current RVU, and therefore recommends to maintain the current value of 1.19 RVUs In addition, the RUC and specialty believed that the pre-service physician time typically took less than 5 minutes as indicated by the survey respondents and therefore recommended 3 minutes instead The RUC believed there should not be a change in the RVU for this service. The RUC recommends physician time data elements of Pre-Service Evaluation of 3 minutes, Intra-Service time of 12 minutes, and Immediate Post Time of 5 minutes, totaling 18 minutes.	☑	2
74160	CT ABDOMEN W/DYE	1 27	1.27	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results carefully, and believed there should not be a change in the work RVU for this service, and therefore recommends to maintain the current value of 1 27 RVUs. In addition, the RUC and specialty believed that the pre-service physician time typically took less than 5 minutes as indicated by the survey respondents and therefore recommended 3 minutes instead The RUC recommends physician time data elements of. Pre-Service Evaluation of 3 minutes, Intra-Service time of 15 minutes, and Immediate Post Time of 5 minutes, totaling 18 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
75552	HEART MRI FOR MORPH W/O DYE	1.60		ACC and ACR commented that the physician work has increased in all areas of the exam. Specifically, in the pre-service period for preparing protocols; in the intra-service period for monitoring, guiding and directing appropriate set-up of sequences and anatomy, post-processing and interpretation; and in the post-service period for review of cases with referring physicians The specialties believe the current work values do not accurately reflect the changes in physician work that have occurred since 1993	The American College of Cardiology and the American College of Radiology believed that the current CPT coding structure for Cardiac MRI (CPT codes 75552 - 75556) did not accurately reflect current practice and as a result is confusing to members of both societies as well as payors for the services. The RUC agreed with the specialty's recommendation to send this Cardiac MRI family of codes to the CPT Editorial Panel for a revision in their CPT descriptor terminology	☑	5
75553	HEART MRI FOR MORPH W/DYE	2.00		ACC and ACR commented that the physician work has increased in all areas of the exam Specifically, in the pre-service period for preparing protocols; in the intra-service period for monitoring, guiding and directing appropriate set-up of sequences and anatomy, post-processing and interpretation; and in the post-service period for review of cases with referring physicians. The specialties believe the current work values do not accurately reflect the changes in physician work that have occurred since 1993	The American College of Cardiology and the American College of Radiology believed that the current CPT coding structure for Cardiac MRI (CPT codes 75552 - 75556) did not accurately reflect current practice and as a result is confusing to members of both societies as well as payors for the services. The RUC agreed with the specialty's recommendation to send this Cardiac MRI family of codes to the CPT Editorial Panel for a revision in their CPT descriptor terminology	☑	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
75554	CARDIAC MRI/FUNCTION	1 83		ACC and ACR commented that the physician work has increased in all areas of the exam. Specifically, in the pre-service period for preparing protocols; in the intra-service period for monitoring, guiding and directing appropriate set-up of sequences and anatomy, post-processing and interpretation, and in the post-service period for review of cases with referring physicians. The specialties believe the current work values do not accurately reflect the changes in physician work that have occurred since 1993.	The American College of Cardiology and the American College of Radiology believed that the current CPT coding structure for Cardiac MRI (CPT codes 75552 - 75556) did not accurately reflect current practice and as a result is confusing to members of both societies as well as payors for the services. The RUC agreed with the specialty's recommendation to send this Cardiac MRI-family of codes to the CPT Editorial Panel for a revision in their CPT descriptor terminology	☑	5
75555	CARDIAC MRI/LIMITED STUDY	1 74		ACC and ACR commented that the physician work has increased in all areas of the exam Specifically, in the pre-service period for preparing protocols, in the intra-service period for monitoring, guiding and directing appropriate set-up of sequences and anatomy, post-processing and interpretation; and in the post-service period for review of cases with referring physicians. The specialties believe the current work values do not accurately reflect the changes in physician work that have occurred since 1993.	The American College of Cardiology and the American College of Radiology believed that the current CPT coding structure for Cardiac MRI (CPT codes 75552 - 75556) did not accurately reflect current practice and as a result is confusing to members of both societies as well as payors for the services The RUC agreed with the specialty's recommendation to send this Cardiac MRI family of codes to the CPT Editorial Panel for a revision in their CPT descriptor terminology.	☑	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
76075	DXA BONE DENSITY, AXIAL	0.30	0.20	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the specialty's survey results carefully, and found that there wasn't sufficient evidence to support the service's current value of 0.30. The RUC believed that there was a disconnect between the time and intensity of this procedure, whereas that the service is more mechanical and less intense than the specialty society's description of work indicated. The RUC believed the work is equivalent to the 25th percentile of the specialty's survey RVU results The RUC therefore recommends 0 20 RVUs for this service. In addition, the RUC and specialty believed that the pre and post-service physician time typically took less than 2 minutes as indicated by the survey respondents and therefore recommends 1 minute instead, for a total time of 6 minutes The RUC recommends physician time data elements of: Pre-Service Evaluation of 1 minute, Intra-Service time of 4 minutes, and Immediate Post Time of 1 minute, totaling 6 minutes	☑	4
76700	US EXAM, ABDOM, COMPLETE	0 81	0.81	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0 81 RVUs The RUC recommends physician time data elements of: Pre-Service Evaluation of 3 minutes, Intra-Service time of 10 minutes, and Immediate Post Time of 4 minutes, totaling 17 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
76830	TRANSVAGINAL US, NON-OB	0 69	0.69	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.69 RVUs. In addition, the RUC and specialty believed that the pre-service physician time typically took less than 5 minutes as indicated by the survey respondents and therefore recommends 3 minutes instead The RUC recommends physician time data elements of. Pre-Service Evaluation of 3 minutes, Intra-Service time of 12 minutes, and Immediate Post Time of 5 minute, totaling 20 minutes.	☑	2
77263	RADIATION THERAPY PLANNING	3 14	3.14	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided However, the RUC and specialty believed that the 25th percentile intra-service physician time was more typical at 75 minutes than the survey median of 90 minutes. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 3.14 RVUs. The RUC recommends physician time only represent the intra-service time period of 75 minutes for this service.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
77280	SET RADIATION THERAPY FIELD	0.70	0 70	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided However, the RUC and specialty also believed that there was no change in physician time for the service despite the survey results that indicated a median intra-service time of 45 minutes (0 pre and post time). The RUC believed that the current Harvard total and intra) time of 23 minutes of physician time was more typical and maintained the current time The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.70 RVUs.	☐	2
77290	SET RADIATION THERAPY FIELD	1.56	1.56	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. However, the RUC and specialty believed that the 25th percentile intra-service physician time was more typical at 70 minutes than the survey median of 90 minutes. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 1 56 RVUs. The RUC recommends physician time only represent the intra-service time period of 70 minutes for this service.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
77300	RADIATION THERAPY DOSE PLAN	0.62	0.62	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided However, the RUC and specialty believed that the 25th percentile intra-service physician time was more typical at 15 minutes than the survey median of 20 minutes. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0 62 RVUs. The RUC recommends physician time only represent the intra-service time penod of 15 minutes for this service	☑	2
77315	TELETX ISODOSE PLAN COMPLEX	1.56	1.56	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. However, the RUC and specialty believed that the 25th percentile intra-service physician time was more typical at 45 minutes than the survey median of 55 minutes The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 1 56 RVUs. The RUC recommends physician time only represent the intra-service time period of 45 minutes for this service.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
77331	SPECIAL RADIATION DOSIMETRY	0.87	0.87	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.87 RVUs. The RUC recommends physician time only represent the intra-service time period of 30 minutes for this service.	☑	2
77334	RADIATION TREATMENT AID(S)	1.24	1 24	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. However, the RUC and specialty believed that the 25th percentile intra-service physician time was more typical at 35 minutes than the survey median of 50 minutes. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 1 56 RVUs. The RUC recommends physician time only represent the intra-service time period of 35 minutes for this service	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
77470	SPECIAL RADIATION TREATMENT	2.09	2.09	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's physician work survey results and discussion with the specialty that the code's current RVU was appropriate for the service provided. However, the RUC and specialty also believed that there was no change in physician time for the service despite the survey results that indicated a median intra-service time of 90 minutes (0 pre and post time). The RUC believed that the current CMS crosswalked total and intra) time of 55 minutes of physician time was more typical and maintained the current time. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0 70 RVUs	☐	2
78306	BONE IMAGING, WHOLE BODY	0 86	0 86	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 0.86 RVUs In addition, the RUC and specialty believed that the intra-service physician time typically took less time than indicated by the survey respondents and therefore recommended 8 minutes of intra-service time instead of 10 minutes. The RUC agreed with the following physician time increments: pre-service evaluation time of 5 minutes, intra-service time of 8 minutes, and immediate post service time of 5 minutes, totaling 18 minutes	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
78315	BONE IMAGING, 3 PHASE	1.02	1.02	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided. The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 1 02 RVUs. In addition, the RUC and specialty believed that the intra-service physician time typically took less time than indicated by the survey respondents and therefore recommended 10 minutes of intra-service time instead of 15 minutes The RUC agreed with the following physician time increments· pre-service evaluation time of 5 minutes, intra-service time of 8 minutes, and immediate post service time of 5 minutes, totaling 18 minutes.	☑	2
78465	HEART IMAGE (3D), MULTIPLE	1.46	1.46	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC believed from the specialty's survey results that the code's current RVU was appropriate for the service provided The RUC and the specialty believed there should not be a change in the RVU for this service, and supported the specialty's recommendation to maintain the current value of 1.46 RVUs. In addition, the RUC and specialty believed that both the pre and post-service physician time typically took less time than indicated by the survey respondents and therefore recommended 5 minutes instead of 10 minutes for each The RUC agreed with the following physician time increments pre-service evaluation time of 5 minutes, intra-service time of 20 minutes, and immediate post service time of 5 minutes, totaling 30 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
78478	HEART WALL MOTION ADD-ON	0 62	0 50	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results carefully, and found that there wasn't sufficient evidence to support the service's current value of 0 62 The RUC could not accept the survey median of 0.90 because the pre intra and post-service time associated with this add-on code could not be substantiated by the specialty. The RUC and specialty agreed that the survey results overestimated the physician time and agreed that there was no pre-service physician work, 5 minutes of intra-service work, and 1 minutes of immediate post time. With this understanding, the RUC believed the 25th percentile of the specialty's survey RVU results reflected the true work for the code The RUC therefore recommends 0.50 RVUs for this service	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
78480	HEART FUNCTION ADD-ON	0 62	0.30	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the specialty's survey results carefully, and found that there wasn't sufficient evidence to support the service's current value of 0 62 The RUC could not accept the survey median of 0.75 because the pre intra and post-service time associated with this add-on code could not be substantiated by the specialty In addition, the RUC and specialty society believed that the work of this procedure was approximately half of the work of 78478 Myocardial perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure) which the RUC valued at 0.50 during this review. The RUC and specialty also agreed that the survey results overestimated the physician time and agreed that there was no pre-service physician work, 5 minutes of intra-service work, and 1 minutes of immediate post time With this understanding, the RUC believed in creating a rank order between 78478 and 78480 and therefore recommends 0.30 RVUs for this service.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
88309	TISSUE EXAM BY PATHOLOGIST	2 28	2.80	CAP commented that the physician work associated with the code has increased primarily based on the changes in cancer protocols utilized in the practice of medicine today As a result, pathologists have seen an increase in the amount of work required to perform a level VI surgical pathology examination The increased work that the pathologist has in accumulating, synthesizing and documenting the pre-eminem cancer staging is not addressed under the current payment value.	The RUC reviewed the specialty survey results and believed the physician work RVU should be increased because of the increased work associated with the changes in cancer protocols and in accumulating, synthesizing and documenting these elements for accurate cancer staging The RUC and specialty however, believed the physician time (intra-service only) for the typical patient to be less than the survey median, and accepted the 25th percentile of 90 minutes and 2.80 RVUs for this service. The RUC believed the difference in the time between the Harvard time and the survey median could be used to estimate the increased work in the code The RUC identified 18 minutes of additional time associated with the increased work with an intensity of 0.03 (0 54), which was then added to the current value of 2.28, to provide support for the 25th percentile survey results of 2 80 RVUs. The RUC recomends a relative work value of code 88309 of 2.80 and an intra-service and total time for the procedure of 90 minutes	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
88321	MICROSLIDE CONSULTATION	1.30	1.63	CAP commented that it the content of consultation code family 88321, 88323, and 88325 have substantially increased since the value was first established	The specialty society representatives first clarified to the RUC members how the physician work had changed recently by describing the typical patient scenario for each of the three pathology consultations The RUC accepted the compelling evidence to consider a change in physician work The change in work is due to the increased number and type of slides undergoing review in the typical case, and in particular, the number of immunohistochemical slides that must undergo review The RUC also believed that the clinical practice of these pathology consultations have changed based on recent literature. The specialty society's survey results supported the specialty's contention that the physician work had increased. The specialty's survey results indicated pathology consultations now take longer to perform, and require more work After further clarification and discussion, the RUC and the specialty society agreed that the level of physician work equals the specialty's 25th percentile survey results. The RUC therefore recommends the following relative value units and physician time components for codes 88321, 88233, and 88325, which represent the 25th percentile specialty society's survey results. Code | Current RVU| Recommended RVU| Current Intra-Service Time |Recommended Intra-Service Time 88321| 1 30 |1.63 |41 minutes-Hrvd |50 minutes 88323| 1.35 |1.83 |42 minutes-Hrvd |56 minutes 88325| 2 22 |2.50 |69 minutes-Hrvd |80 minutes The RUC recommends a work rvu of 1.63 for code 88321 and an intra-service and total time of 50 minutes	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
88323	MICROSLIDE CONSULTATION	1 35	1 83	CAP commented that it the content of consultation code family 88321, 88323, and 88325 have substantially increased since the value was first established.	The specialty society representatives first clarified to the RUC members how the physician work had changed recently by describing the typical patient scenario for each of the three pathology consultations. The RUC agreed that there was compelling evidence to consider a change in physician work The change in work is due to the increased number and type of slides undergoing review in the typical case, and in particular, the number of immunohistochemical slides that must undergo review The RUC also believed that the clinical practice of these pathology consultations have changed based on recent literature The specialty society's survey results supported the specialty's contention that the physician work had increased. The specialty's survey results indicated pathology consultations now take longer to perform, and require more work. After further clarification and discussion, the RUC and the specialty society agreed that the level of physician work equals the specialty's 25th percentile survey results The RUC therefore recommends the following relative value units and physician time components for codes 88321, 88233, and 88325, which represent the 25th percentile specialty society's survey results· Code | Current RVU| Recommended RVU| Current Intra-Service Time |Recommended Intra-Service Time 88321| 1.30 |1.63 |41 minutes-Hrvd |50 minutes 88323| 1.35 |1.83 |42 minutes-Hrvd |56 minutes 88325| 2.22 |2 50 |69 minutes-Hrvd |80 minutes The RUC recommends a work rvu of 1 83 for code 88323 and an intra-service and total time of 56 minutes	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
88325	COMPREHENSIVE REVIEW OF DATA	2.22	2.50	CAP commented that it the content of consultation code family 88321, 88323, and 88325 have substantially increased since the value was first established.	The specialty society representatives first clarified to the workgroup members how the physician work had changed recently by describing the typical patient scenario for each of the three pathology consultations. The RUC agreed that there was compelling evidence to consider a change in physician work. The change in work is due to the increased number and type of slides undergoing review in the typical case, and in particular, the number of immunohistochemical slides that must undergo review. The RUC also believed that the clinical practice of these pathology consultations have changed based on recent literature The specialty society's survey results supported the specialty's contention that the physician work had increased. The specialty's survey results indicated pathology consultations now take longer to perform, and require more work. After further clarification and discussion, the RUC and the specialty society agreed that the level of physician work equals the specialty's 25th percentile survey results. The RUC therefore recommends the following relative value units and physician time components for codes 88321, 88233, and 88325, which represent the 25th percentile specialty society's survey results· Code | Current RVU| Recommended RVU| Current Intra-Service Time |Recommended Intra-Service Time 88321| 1.30 |1 63 |41 minutes-Hrvd |50 minutes 88323| 1.35 |1 83 |42 minutes-Hrvd |56 minutes 88325| 2 22 |2.50 |69 minutes-Hrvd |80 minutes The RUC recommends a work rvu of 2.50 for code 88325 and an intra-service and total time of 80 minutes.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
90465	IMMUNE ADMIN 1 INJ, < 8 YRS	0 17		AAP commented that the work of vaccine counseling has increased due to the uptake of new combination vaccines such as Pediarix (DPaT-IPV-HBV). When physicians follow current CDC and AAP recommendations to use combination vaccines found safe and effective, the implementation of those recommendations results in a financial penalty to the physician. The current relative values do not reflect this work. In addition, there is increased work for vaccine counseling typically required in young children, which is the rationale for the existence of the codes themselves. Codes 90465-90468 include a specific pediatric age limit (under 8 years) as well as the requirement for physician vaccine counseling that typically occurs in this patient population. The existing RVUs for codes 90465-90468 do not reflect this difference when compared to the values of codes 90471-90474.	The American Academy of Pediatrics requested the RUC to refer codes 90465-90468 to the CPT Editorial Panel because of the increased physician work associated with new combinations of vaccines that changes the work and description of the codes The RUC agreed with AAP that it would be best to address the descriptions of the codes and then the physician work through the RUC process. The RUC recommends that code 90465-90468 be referred to CPT.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
90466	IMMUNE ADMIN ADDL INJ, < 8 Y	0 15		AAP commented that the work of vaccine counseling has increased due to the uptake of new combination vaccines such as Pediarix (DPaT-IPV-HBV). When physicians follow current CDC and AAP recommendations to use combination vaccines found safe and effective, the implementation of those recommendations results in a financial penalty to the physician. The current relative values do not reflect this work. In addition, there is increased work for vaccine counseling typically required in young children, which is the rationale for the existence of the codes themselves. Codes 90465-90468 include a specific pediatric age limit (under 8 years) as well as the requirement for physician vaccine counseling that typically occurs in this patient population. The existing RVUs for codes 90465-90468 do not reflect this difference when compared to the values of codes 90471-90474	The American Academy of Pediatrics requested the RUC to refer codes 90465-90468 to the CPT Editorial Panel because of the increased physician work associated with new combinations of vaccines that changes the work and description of the codes. The RUC agreed with AAP that it would be best to address the descriptions of the codes and then the physician work through the RUC process. The RUC recommends that code 90465-90468 be referred to CPT	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
90467	IMMUNE ADMIN O OR N, < 8 YRS	0.00		AAP commented that the work of vaccine counseling has increased due to the uptake of new combination vaccines such as Pediarix (DPaT-IPV-HBV). When physicians follow current CDC and AAP recommendations to use combination vaccines found safe and effective, the implementation of those recommendations results in a financial penalty to the physician. The current relative values do not reflect this work. In addition, there is increased work for vaccine counseling typically required in young children, which is the rationale for the existence of the codes themselves Codes 90465-90468 include a specific pediatric age limit (under 8 years) as well as the requirement for physician vaccine counseling that typically occurs in this patient population. The existing RVUs for codes 90465-90468 do not reflect this difference when compared to the values of codes 90471-90474.	The American Academy of Pediatrics requested the RUC to refer codes 90465-90468 to the CPT Editorial Panel because of the increased physician work associated with new combinations of vaccines that changes the work and description of the codes. The RUC agreed with AAP that it would be best to address the descriptions of the codes and then the physician work through the RUC process The RUC recommends that code 90465-90468 be referred to CPT.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
90468	IMMUNE ADMIN O/N, ADDL < 8 Y	0.00		AAP commented that the work of vaccine counseling has increased due to the uptake of new combination vaccines such as Pediarix (DPaT-IPV-HBV). When physicians follow current CDC and AAP recommendations to use combination vaccines found safe and effective, the implementation of those recommendations results in a financial penalty to the physician. The current relative values do not reflect this work. In addition, there is increased work for vaccine counseling typically required in young children, which is the rationale for the existence of the codes themselves Codes 90465-90468 include a specific pediatric age limit (under 8 years) as well as the requirement for physician vaccine counseling that typically occurs in this patient population The existing RVUs for codes 90465-90468 do not reflect this difference when compared to the values of codes 90471-90474	The American Academy of Pediatrics requested the RUC to refer codes 90465-90468 to the CPT Editorial Panel because of the increased physician work associated with new combinations of vaccines that changes the work and description of the codes. The RUC agreed with AAP that it would be best to address the descriptions of the codes and then the physician work through the RUC process The RUC recommends that code 90465-90468 be referred to CPT	☐	5
90473	IMMUNE ADMIN ORAL/NASAL	0 00		AAP commented that the RVUs for this code were not published in the 2005 Medicare physician fee schedule and its status from N to R AAP requested CMS publish the RVUs and CMS requested that the issue be discussed at the 2005 5 Year Review	The American Academy of Pediatrics requested to withdraw codes 90473 and 90474 from consideration at the 2005 Five Year Review.	☐	7

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
90474	IMMUNE ADMIN ORAL/NASAL ADDL	0 00		AAP commented that the RVUs for this code were not published in the 2005 Medicare physician fee schedule and its status from N to R AAP requested CMS publish the RVUs and CMS requested that the issue be discussed at the 2005 5 Year Review	The American Academy of Pediatrics requested to withdraw codes 90473 and 90474 from consideration at the 2005 Five Year Review.	☐	7
93010	ELECTROCARDIOGRAM REPORT	0.17	0.17	CMS submitted - (3) This service was selected for review because it has experienced advances in technology that have likely resulted in a modification to the physician work required to accomplish the procedure.	The RUC reviewed the specialty's survey results and recommendation carefully, and in relation to the work of code 93000 Electrocardiogram, routine ECG with at least 12 leads, with interpretation and report (work RVU = 0 17) Thus, the RUC believed there should not be a change in the RVU for this service, and recommends to maintain the current value of 0.17 RVUs The RUC and the specialty agreed that the survey respondents overestimated the physician time associated with this code and recommends an intra-service time of 4 minutes and 1 minute of immediate post time.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
93015	CARDIOVASCULAR STRESS TEST	0 75	0.75	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the specialty's survey results and recommendation carefully, and in relation to the work of code 93016 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress, physician supervision only, without interpretation and report (work RVU = 0.45). 67% of the respondents stated there was no change in physician work, the RUC believed there should not be a change in the RVU for this service, and recommends to maintain the current value of 0.75 RVUs The RUC and the specialty agreed with slight changes to the physician time to reflect the typical patient and recommends the following time increments· pre-service evaluation of 2 minutes, intra-service time of 15 minutes and 4 minutes of immediate post time	☑	2
93018	CARDIOVASCULAR STRESS TEST	0 30	0 30	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the specialty's survey results and recommendation carefully, but did not agree with the specialty that the work RVU should be doubled 73% of the respondents noted no change in physician work The RUC found that there wasn't sufficient evidence to support a change in the current RVU, and recommends to maintain the current value of 0.30 RVUs The RUC and the specialty also agreed with slight changes to the physician time to reflect the typical patient and recommends the following time increments: pre-service evaluation of 2 minutes, intra-service time of 5 minutes and 5 minutes of immediate post time.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
93325	DOPPLER COLOR FLOW ADD-ON	0.07		CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results and rationale and believed that code 93307 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete (work rvu = 0 92) was typically billed with 93325 The RUC could not recommend a change in the value of the code without CPT review of the code. The RUC recommends code 93325 be refered to CPT so that the code may be revised to include the work of code 93307	☐	5
94010	BREATHING CAPACITY TEST	0 17	0.17	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the specialty's survey results and recommendation carefully, and agreed with the specialty that there had not been a change in physician work. The RUC and specialty believed that the survey respondents overestimated the physician time for this procedure It was agreed that for the typical patient encounter, there would be no time for pre-service evaluation as it is typically billed with an E/M code, 5 minutes of intra-service work, and 2 minutes of immediate post time. The RUC recommends the Work RVU of 94010 be maintained at its current 0.17 RVUs.	☑	2
94657	CONTINUED VENTILATOR MGMT	0 83		CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results and rationale, and believed there is a bimodal patient distribution of procedure. The RUC referred the specialty to the CPT Editorial Panel to have the code split into two distinct patient population specific codes.	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95004	PERCUT ALLERGY SKIN TESTS	0 00		JCAAI commented that there is physician work in these services that is not being recognized and not reimbursed through any other codes	The RUC heard from the specialty that the code contained the physician work of staff supervision and the interpretation of the tests results Currently the code is typically billed with an E/M service which according to CPT the "actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the level of E/M services " The RUC, referred the specialty to CPT Editorial Panel for clarification and possible revision of the code.	☐	5
95024	ID ALLERGY TEST, DRUG/BUG	0.00		JCAAI commented that there is physician work in these services that is not being recognized and not reimbursed through any other codes.	The RUC heard from the specialty that the code contained the physician work of staff supervision and the interpretation of the tests results Currently the code is typically billed with an E/M service which according to CPT the "actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the level of E/M services." The RUC, referred the specialty to CPT Editorial Panel for clarification and possible revision of the code.	☐	5
95027	ID ALLERGY TITRATE-AIRBORNE	0.00		JCAAI commented that there is physician work in these services that is not being recognized and not reimbursed through any other codes.	The RUC heard from the specialty that the code contained the physician work of staff supervision and the interpretation of the tests results. Currently the code is typically billed with an E/M service which according to CPT the "actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the level of E/M services." The RUC, referred the specialty to CPT Editorial Panel for clarification and possible revision of the code	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95115	IMMUNOTHERAPY, ONE INJECTION	0.00		JCAAI commented that there is physician work in these services that is not being recognized and not reimbursed through any other codes	The Joint Council of Allergy, Asthma, and Immunology (JCAAI) and the American Academy of Otolargyngic Allergy (AAOA) requested this code be withdrawn from consideration at the 2005 Five Year Review.	☐	7
95117	IMMUNOTHERAPY INJECTIONS	0 00		JCAAI commented that there is physician work in these services that is not being recognized and not reimbursed through any other codes.	The Joint Council of Allergy, Asthma, and Immunology (JCAAI) and the American Academy of Otolargyngic Allergy (AAOA) requested this code be withdrawn from consideration at the 2005 Five Year Review.	☐	7
95144	ANTIGEN THERAPY SERVICES	0.06	0.06	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results showing a requested change the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. In addition, the RUC and specialty also believed that surveyed physician time for the service seemed overestimated and did not reflect the typical patient. The RUC and specialty agreed that there is typically 3 minutes of intra-service time and no pre or post operative work associated with the service. The RUC recommends the Work RVU of 0.06 for code 95144 be maintained.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95165	ANTIGEN THERAPY SERVICES	0 06	0.06	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results showing a requested change the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. In addition, the RUC and specialty also believed that surveyed physician time for the service seemed overestimated and did not reflect the typical patient The RUC and specialty agreed that there is typically 3 minutes of intra-service time and no pre or post operative work associated with the service The RUC recommends the Work RVU of 0 06 for code 95165 be maintained.	☑	2
95816	EEG, AWAKE AND DROWSY	1.08	1.08	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC reviewed the specialty's survey results and recommendation carefully, and agreed with the specialty that there had not been a change in physician work. The RUC found that there wasn't evidence to support a change in the current RVU, and therefore recommends to maintain the current value of 1.08 RVUs. The RUC agreed with the survey data including all of the physician time elements. The RUC recommends physician time data elements of Pre-Service Evaluation of 5 minutes, Intra-Service time of 15 minutes, and Immediate Post Time of 10 minutes, totaling 30 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95819	EEG, AWAKE AND ASLEEP	1.08	1 08	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results showing a requested change the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. The RUC recommends to maintain the current value of 1.08 RVUs. The RUC agreed with the physician time survey data and recommends all of the physician time elements The RUC recommends physician time data elements of: Pre-Service Evaluation of 5 minutes, Intra-Service time of 15 minutes, and Immediate Post Time of 10 minutes, totaling 35 minutes.	☑	2
95861	MUSCLE TEST, 2 LIMBS	1.54	1.54	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results showing a requested change the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. The RUC also reviewed code 95860 Needle electromyography; one extremity with or without related paraspinal areas (Work RVU = 0.96). The RUC recommends to maintain the current value of 1.54 RVUs The RUC agreed with the physician time survey data and recommends all of the physician time elements The RUC recommends physician time data elements of· Pre-Service Evaluation of 15 minutes, Intra-Service time of 25 minutes, and Immediate Post Time of 10 minutes, totaling 50 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95872	MUSCLE TEST, ONE FIBER	1.50	3 00	AANEM requested the code be revalued as it is a very time intensive examination and is apparently undervalued when compared to other needle electromyography studies, such as 95860 One extremity needle electromyography (work rvu = 0.96) and 95861 Two extremity needle electromyography (work rvu = 1 54). The specialty maintains that single fiber needle electromyography is often even more challenging and time consuming than routine electromyography and therefore should have a greater RVU than a two limb needle electrotromyography In addition, single fiber needle electromyography takes particular expertise and is only performed by electromyographers with additional training in this technique.	The RUC reviewed the specialty's survey results and recommendation carefully, and agreed with the specialty that the service was undervalued. It was explained that this codes was at least twice the work of code 95861 Needle electromyography, two extremities with or without related paraspinal areas (Work RVU = 1 54). The RUC also reviewed the work of codes 95810 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist (Work RVU = 3 52) and 95978 Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming, first hour (Work RVU = 3.50), and believed the recommended work RVU would properly rank order the code. The RUC agreed with the survey data including all of the physician time elements. The RUC recommends a work RVU of 3.00 for code 95872. The RUC recommends physician time data elements of: Pre-Service Evaluation of 15 minutes, Intra-Service time of 60 minutes, and Immediate Post Time of 20 minutes, totaling 95 minutes	☑	1

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95900	MOTOR NERVE CONDUCTION TEST	0.42	0.42	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)	The RUC found that there had not been a change in physician work and did not believe an increase in the work RVU, as suggested by the specialty, was warranted at this time Code 95903 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study (Work RVU= 0.60) was discussed in relation to 95900 and considered to be more work. The RUC recommends to maintain the current value of 0 42 RVUs In addition, the RUC and specialty also believed that surveyed physician time for the service seemed overestimated and did not reflect the typical patient. The RUC and specialty agreed on the following time elements; that the pre-service evaluation time - 4 minutes, intra-service time - 6 minutes, and immediate post-service time - 4 minutes, for a total time of 14 minutes.	☑	2
95904	SENSE NERVE CONDUCTION TEST	0.34	0.34	CMS submitted - (1) This service was selected for review because it has never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information).	The RUC reviewed the specialty's survey results showing a requested change the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. The RUC noted that 74% of the survey respondents believed the physician work had not changed. In addition, the RUC and specialty also believed that surveyed physician time for the service seemed overestimated and did not reflect the typical patient The RUC and specialty agreed on the following time elements, that the pre-service evaluation time - 4 minutes, intra-service time - 5 minutes, and immediate post-service time - 3 minutes, for a total time of 12 minutes. The RUC recommends the Work RVU of 0 34 for code 95904 be maintained.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95925	SOMATOSENSORY TESTING	0.54	0.54	The AANEM commented that this code be revalued as its current physician work RVU does not encompass the full physician time, intensity, and effort for the service.	The RUC did not hear compelling evidence from the specialty to change the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. The RUC noted that 69% of the survey respondents believed the physician work had not changed. The RUC however, agreed with the physician time survey data and recommends all of the physician time elements The RUC recommends the Work RVU of 0.54 for code 95925 be maintained The RUC recommends physician time data elements of: Pre-Service Evaluation of 6.5 minutes, Intra-Service time of 15 minutes, and Immediate Post Time of 10 minutes, totaling 31.5 minutes.	☑	2
95926	SOMATOSENSORY TESTING	0.54	0.54	The AANEM commented that this code be revalued as its current physician work RVU does not encompass the full physician time, intensity, and effort for the service.	The RUC did not hear compelling evidence from the specialty to change the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time The RUC noted that 69% of the survey respondents believed the physician work had not changed The RUC however, agreed with the physician time survey data and recommends all of the physician time elements The RUC recommends the Work RVU of 0.54 for code 95926 be maintained. The RUC recommends physician time data elements of. Pre-Service Evaluation of 6 5 minutes, Intra-Service time of 15 minutes, and Immediate Post Time of 10 minutes, totaling 31 5 minutes.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95927	SOMATOSENSORY TESTING	0.54	0.54	The AANEM commented that this code be revalued as its current physician work RVU does not encompass the full physician time, intensity, and effort for the service.	The RUC found no compelling evidence from the specialty to change the RVU for this service, and did not believe an increase, as suggested by the specialty, was warranted at this time. In addition, the RUC and specialty also believed that surveyed physician time for the service seemed overestimated and did not reflect the typical patient The RUC and specialty agreed on the following time elements, that the pre-service evaluation time - 6.5 minutes, intra-service time 15 minutes, and immediate post-service time - 10 minutes, for a total time of 16 minutes The RUC recommends the Work RVU of 0.54 for code 95927 be maintained. The RUC recommends physician time data elements of· Pre-Service Evaluation of 6.5 minutes, Intra-Service time of 15 minutes, and Immediate Post Time of 10 minutes, totaling 31 5 minutes.	☑	2

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Action Key (1 = Adopt the recommended increase in the work RVU, 2 = Maintain the current work RVU, 3 = Adopt the recommended decrease in the work RVU, 4 = Suggest a new RVU; 5 = Refer the code to CPT; 6 = No consensus, 7 = Accept withdrawal by commenter, without prejudice; 8 = No Level of Interest submitted, no Recommendation submitted)

CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public Comment Letter	RUC Rationale	Change in Time from 2005?	Action Key
95953	EEG MONITORING/COMPUTER	3 08	3.30	AAN commented that 95953 should be revalued. As the time, intensity, and complexity of the physician work involved in this code justifies a higher work RVU, than 3 08 work RVUs	The RUC found compelling evidence from the specialty to change the RVU for this service The RUC believed, from the specialty's survey results and discussion, the true value of the service was between the 25th percentile of the specialty's survey results (2.80) and the median value (3 50). The RUC reviewed code 95810 Polysomnography, sleep staging with 4 or more additional parameters of sleep, attended by a technologist (Work RVU= 3 52), and believed the 10 minute physician time difference of 95810 could be subtracted from the surveyed code in order to find the relative value (10 * an IWPUT of .0224 = 0.22) (3.52 - 0 22 = 3 30). The RUC recommends the Work RVU of 3.30 for code 95953 The RUC also agreed with the physician time survey data and recommends all of the physician time elements The RUC recommends physician time data elements of: Pre-Service Evaluation of 10 minutes, Intra-Service time of 60 minutes, and Immediate Post Time of 15 minutes, totaling 85 minutes	☑	4

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

Action Key (1 = Adopt the recommended increase in the work RVU; 2 = Maintain the current work RVU; 3 = Adopt the recommended decrease in the work RVU; 4 = Suggest a new RVU, 5 = Refer the code to CPT; 6 = No consensus; 7 = Accept withdrawal by commenter, without prejudice; 8 = No Level of Interest submitted, no Recommendation submitted)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
ANESTHESIA SUMMARY OF RECOMMENDATION

CPT Code:00797 Global Period:XXX **Recommended Base Unit Value: 11**

CPT Descriptor: Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; gastric restrictive procedure for morbid obesity

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 44-year-old man (height: 5ft-11in; weight 390 lbs; BMI 55 kg/m2) presents with a history of Type II diabetes controlled with three oral hypoglycemic medications and hypertension controlled with two medications. A recent sleep study showed severe obstructive sleep apnea for which he was placed on CPAP with subjective improvement, but complains of poor tolerance of the mask. His gastroesophageal reflux is controlled with an H2-blocker, but his mobility is compromised due to severe arthritis of his lower back and right knee. Family and diet history confirm morbid obesity began at age nine. The patient underwent multiple weight loss programs, losing up to 75 pounds three times. However, the weight loss was never maintained for more than six months and each weight regain was more than what was originally lost. Weight loss programs utilized included very low calorie diets, Weight Watchers, exercise, appetite suppressants, and meal replacements. At operation, he undergoes a laparoscopic gastric restrictive procedure with gastric bypass and Roux-en Y gastroenterostomy.

Percentage of Survey Respondents who found Vignette to be Typical: 100.00%

Description of Pre-Service Work: The patient arrives at the Pre-Anesthesia Assessment clinic prior to the planned surgery. A medical history is taken, a systems review conducted, a physical examination emphasizing cardiorespiratory elements and assessment of the upper airway (in anticipation of endotracheal intubation) is performed, and room air oxygen saturation is measured. Background medical information from his physicians, including prior pulmonary function tests, sleep studies, electrocardiograms, and cardiac ultrasound and chest x-ray reports, is obtained and reviewed. The patient is counseled about the plans for general anesthesia and the possibility of postoperative mechanical ventilation. Informed consent is obtained

Description of Intra-Service Work: On the day of surgery, the record is reviewed and any interim data is assessed. Informed consent is confirmed. A peripheral intravenous catheter is inserted. A sedative is administered intravenously. The patient receives an antisialogogue and nebulized local anesthetic treatment. He is transported to the operating room and is transferred to the special heavy capacity operating table. A special extra-large non-invasive blood pressure is obtained and monitoring begun, EKG leads applied and oximetry resumed. Initial vital signs are obtained and medical interventions initiated as necessary to assure hemodynamic stability during induction. Anesthesia induction commences, and the anesthesiologist performs direct laryngoscopy and oral-tracheal intubation. Once the placement of the endotracheal tube has been confirmed by visualization, end tidal carbon dioxide and breath auscultation, general anesthesia and a non-depolarizing muscle relaxant are administered. Because of the decreased functional residual capacity, the patient's oxygen saturation usually decreases rapidly and positive pressure ventilation is rapidly initiated. At this point mechanical ventilation is initiated to maintain adequate oxygenation, normocarbia and acceptable tidal volumes and inflation pressures. Because of the patient's body habitus, peak airway pressures are likely to be excessive and manipulation of tidal volume and rate to produce adequate gas exchange with minimal risk of barotrauma is required. Inhaled volatile anesthetic and intravenous narcotic are titrated to blood pressure and heart rate parameters. The patient is positioned for surgery in the supine, reverse Trendelenburg position with attention to protecting peripheral nerves and pressure points, including the olecranon fossae, brachial plexus and the heels. A warm air blanket is positioned over the patient, avoiding the surgical field, to maintain normothermia. A final verification of operation and antibiotic administration is done before the surgeon begins the procedure. Intra

operatively, neuromuscular blockade, temperature, urinary output, and fluid balance are regularly monitored and adjustments made as the patient's condition warrants. Serial blood glucose determinations are made and an intravenous insulin infusion is begun if needed. A nasogastric tube is inserted and subsequently a calibrated bougie is passed into the proximal stomach under manual guidance to assist the surgeon. The nasogastric tube is cautiously withdrawn before the final anastomosis is done. As the operation draws to an end, an opioid is carefully administered for postoperative analgesia. Inhaled anesthetic is withdrawn gradually and neuromuscular blockade reversed by administration of anticholinesterase and anticholinergic drugs. The patient's level of consciousness, ventilatory efforts, capnogram and oximetry are assessed to determine the adequacy of spontaneous respiration. If these parameters appear satisfactory, the trachea is extubated and mask oxygen administered. The patient is then transported to the PACU with appropriate monitoring. In the PACU, a patient history and synopsis of intraoperative events, including fluids administered, blood loss, urinary output, drugs administered, vital sign trends is provided to the nursing staff.

Description of Post-Service Work: The anesthesiologist continues to participate in the management of postoperative analgesia, fluid balance and respiratory care while the patient is cared for in the PACU before the patient is transferred to the next level of care. Postoperatively the patient is evaluated to ascertain recovery from anesthesia and to determine if any post-anesthetic complications have occurred. Appropriate follow- up or interventions for anesthetic related complications are initiated during the post anesthesia visit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James D Grant, MD Brenda S Lewis, DO					
Specialty(s):	Anesthesiology					
CPT Code:	00797					
Sample Size:	94	**Resp n:**	40	**Resp %:** 42.5%		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey Base Unit Values:		7	10	**11**	12	20
Pre-Anesthesia Time:		**15.00**	**20.00**	**30.00**	**45.00**	**120.00**
Intra-op Anesthesia Time:		100.00	150.00	**185.00**	240.00	480.00
Post-Anesthesia Time:				**30.00**		

To calculate above and below time recommendations, tab here

KEY REFERENCE SERVICE:

Key CPT Code	Global	Base Unit Value
00790	XXX	7

CPT Descriptor Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified

Other Reference CPT Code	Global	Base Unit Value
00792	XXX	13

CPT Descriptor Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of liver hemorrhage (excluding liver biopsy)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17

TIME ESTIMATES (Median)	**CPT Code: 00797**	**Key Reference CPT Code: 00790**
Median Pre-Service Time	30.00	0.00
Median Intra-Service Time	185.00	0.00
Median Post-service Time	30.00	0.00
Median Total Time	**245.00**	**0.00**

Calculate total reference time tab here n

INTENSITY/COMPLEXITY MEASURES (Mean)		
Mental Effort and Judgement (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.94	2.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.41	2.47
Urgency of medical decision making	4.00	2.88
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.59	2.88
Physical effort required	4.65	2.76
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.88	2.82

		CPT Code:
Outcome depends on the skill and judgement of physician	4.59	3.06
Estimated risk of malpractice suit with poor outcome	4.53	3.29

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Anesthesia intensity/complexity	4.18	2.76
Intra-Op Anesthesia intensity/complexity	4.53	2.94
Post-Anesthesia intensity/complexity	4.06	2.71

ADDITIONAL RATIONALE

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*
We wanted to address concerns about the vignette used when code 00797 was originally valued. We wanted to be certain that the vignette accurately described the typical patient for surgeries performed in 2005. According to the American Society for Bariatric Surgery, a laparoscopic Roux-en-Y is the most commonly performed gastric restrictive procedure. The vignette used in our survey is identical to the one the RUC database lists for CPT code 43644 - Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less). All of our survey respondents agreed that the survey vignette did describe their typical patient. Since code 43644 was new to CPT in 2005, the vignette has the benefit of recent RUC review.

Almost half of our respondents used code 00790 - Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; NOS as their reference service. The next most frequently selected code was 00792 - Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; partial hepatectomy or management of liver hemorrhage (excluding liver biopsy). The RUC data base does not list times for either of these codes. While we maintain that the separate reporting of anesthesia time would account for any difference between intra-service anesthesia time and intra-service surgical time, we do note that the survey median intra-service time for code 00797 is 185 minutes and the median intra-service time for code 43644 is 180 minutes.

A comparision of the intensity/complexity measures of code 00797 and the key reference service (code 00790) show the values for 00797 are always notably higher. We compared code 00797 to other anesthesia codes that have been through recent RUC review. Code 00540 - Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified - has 12 base units. This code is very similar to code 00797 in terms of patient complexity, introperative intensity, and post-operative respiratory management challenges. Code 01173 - Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum - with 12 base units involves complex blood, fluid and other hemodynamic management responsibilities comparable to 00797's complex airway, ventilatory, positioning and ongoing medical management tasks.

Fiberoptic intubation is not typical for the patient described in the vignette, however, for massively obese patients (450+ lbs) an awake fiberoptic intubation is typical. In addition, all of these patients require extremely close

attention to airway management and unexpectedly difficult intubations (with an increased risk of airway-related complications and physician work and stress) are a frequent occurence. Based on these observations and on a thorough review of the survey responses, we recommend that code 00797 be assigned a base unit value of 11 --the 50th percentile in our survey. The recommendation of 9 units in 2001 did not take into account all the elements described above. Assuming anesthesia time of 3 hours, ASA's current recommendation of 11 base units for code 00797 would represent a 20% increase from the reference service code 00790 (7 base +12 time vs 11 base + 12 time). This is in line with the intra-service increases seen in the surgical codes (see Compelling Evidence Rationale). Almost 2/3 of our survey respondents felt that the work of performing this service has changed in the last 5 years and 84% of those respondents indicated that these patients are moré complex(i.e., more work).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In the 2002 Final Rule, CMS provided this rationale for rejecting the RUC's recommendation of 9 units: "While obese patients do make the work of an anesthesiologist more difficult, we believe that the vignette used in the RUC survey was atypical and exaggerated the required work because the patient in the vignette was described as having asthma. We believe the work of an anesthesiologist is greater for patients undergoing Whipple procedures because, typically, these patients are sicker and require longer operative time and more intense anesthesia care than patients undergoing gastric restrictive procedures. Therefore, we are assigning 8 base units to 00797."

Citing asthma as potentially exaggerating the required work ignores that sleep apnea, a far more serious concern to anesthetic management, was not cited as one of the coexisting conditions in the vignette. Both patient evaluation and selection criteria for bariatric surgery have substantially evolved since 2001. Before surgical intervention is offered, the patient must suffer from a number of comorbidities and have failed conventional weight loss therapies. Since

CMS accepted our request to include 00797 in this Five-Year Review, ASA has addressed the Agency's criticism of our 2001 vignette by providing our survey respondents with the same vignette submitted by our surgical colleagues in February 2004, when they presented new codes for laparoscopic gastric bypass procedures for obesity management These new vignettes describe patients more complex than the one described in 2001. We disagree with CMS' contention that a patient with pancreatic cancer is typically more complex to manage than a patient with morbid obesity and its associated comorbid conditions. In addition, we believe that CMS erred in citing the longer intraservice time for a Whipple procedure as compared to 00797 as a reason for rejecting the RUC's recommendation because separate reporting of anesthesia time adequately accounts for any difference in intraservice time.

This service involves all aspects of anesthesia work involved in caring for morbidly obese patients undergoing gastric restrictive procedures. Since the approval of this anesthesia code, two new laparoscopic surgical procedures (43644 and 43645) have been approved by CPT and valued by CMS after RUC review. Several more procedures are currently under review. These new codes have been assigned work values greater than the older open procedures, with the higher value being associated with a more complex intraservice period (example: 43644 with 27.83RVUw and 43846 with 24.01 RVUw). During discussion at the RUC, the consensus opinion expressed was that these patients were very complex and offered a "technically challenging surgical terrain." We contend that the anesthetic terrain is also techically challenging.

The RUC recommended a value of 9 base units to CMS at its April 2001 meeting after analyzing the results of a work survey conducted earlier that year. This represented a deliberate increase of 2 base units over the value of the reference service, 00790 (Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified.) The RUC considered the relatively greater complexity of the gastric bypass service occasioned by positioning the morbidly obese patient, maintaining his or her airway and managing the common cardiovascular and ventilatory problems associated with these patients. The RUC specifically noted the increased difficulty of providing anesthesia to these patients because of their multiple comorbidities.

The recent and growing experience in surgical and anesthetic management of these patients clearly demonstrate very high morbidity and mortality rates in this patient population. Improved understanding and awareness of the interaction between anesthetic care and the common comorbidities of sleep apnea, difficult intubation status, pulmonary hypertension, metabolic syndrome and atherosclerotic vascular disease has led to increased anesthetic work in pre-service evaluation and post-service care. Additionally, the intensity and complexity of medical decision making in the intraservice anesthetic period has also increased at least in part due to the increasing complexity of the surgical interventions reported under 00797.

CMS' decision to reject the RUC's recommendation in 2002 and assign 8 base units to this code resulted in less than a 5% increased value for this service as compared to an anesthetic for an upper abdominal intraperitoneal procedure of the same duration in the non-obese. ASA is convinced that this increment does not reflect the increased complexity and intensity involved in the management of these patients. We also believe that the RUC fairly valued the service at the time of its presentation; however, recent changes in the type and complexity of surgical procedures reported under this code and a more widespread awareness of the management issues associated with the care of the morbidly obese has likely changed anesthesia work for this procedure since it was considered in 2001. The anesthesiology community has become increasingly familiar with gastric restrictive and bypass procedures for morbid obesity due to the significant increase in frequency in surgical management for this condition. We believe that this increased awareness has led to a more accurate assessment of current physician work through the RUC survey process.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 63% No 37%

A. This service represents new technology that has become more familiar (i.e., less work):

I agree 24% I do not agree 76%

B. Patients requiring this service are now:
more complex (more work) 84% less complex (less work) 0% no change 16%

C. The usual site-of-service has changed:
from outpatient to inpatient 4% from inpatient to outpatient 0% no change 96%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 00797

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:31622 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **2.80**
RUC RVU: **2.78**

CPT Descriptor: Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure); percutaneous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old man undergoes a diagnostic fiberoptic bronchoscopy evaluation of hemoptysis. His chest x-ray is normal.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work:
* Hospital admission and preprocedural work-up, review of records, communicaiton with other professionals, patient and family.
* Obtain informed consent.
* Dress, don lead apron (in the event fluoroscopy is required), and waiting time before the procedure.
* Preparing and positioning patient and equipment.
* The physician examines the patient to verify that the patient can undergo the procedure.
The physician verifies the identity of the patient and the procedure to be performed in accord with JCAHO regulations.

Description of Intra-Service Work:
* The patient is placed on supplemental oxygen in the endoscopy suite which has resuscitative equipment in place.
* An IV is started and the physician supervised the nebulized administration of inhaled topical anesthesia.
* The physician next applies local topical anesthesia to the propharynx and nasopharanx
* The physician then supervises administration of moderate sedation while a registered nurse or physician assistant properly monitors the pulse, blood pressure, SPO2, and ECG.
* The physician inserts the bronchoscope through the upper airways noting any abnormalities. The vocal cords are visualized and the structure and function are noted.
* The bronchoscope is advanced into the tracheobronchial tree. The patient has mild erythema throughout the tracheobronchial tree. In the right lower lobe blood is seen coming from the right posterior basilar segment.
* Sterile saline washings of this bronchus are obtained and sent for culture and cytologic examination.

Description of Post-Service Work:
* The physician examines the patient post-endoscopy and pre-discharge from the facility to ascertain that no complications, such as bleeding, plugging, or shortness of breath have occurred.
* The findings from the bronchoscopy are explained to the patient and/or family/friend.
* The physician again reinforces previous instructions about post-procedure complications.
* The physician communicates results to the referring physician.

URVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005
Presenter(s):	Alan Plummer, MD, ATS and Edward Diamond, MD, ACCP
Specialty(s):	Pulmonary

CPT Code:	31622		
Sample Size:	170	Resp n: 48	Response: 28.23 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	2.80	**2.95**	3.50	8.00
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
Intra-Service Time:	15.00	20.00	**30.00**	40.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	15.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
31623	000	2.88

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with brushing or protected brushings

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
32000	000	1.54

CPT Descriptor 1 Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent

MPC CPT Code 2	Global	Work RVU
32020	000	3.97

CPT Descriptor 2 Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema) (separate procedure)

Other Reference CPT Code	Global	Work RVU
31625	000	3.36

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance, with bronchial or endobronchial biopsy(s), single or multiple sites

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 56.2 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 31622	Key Reference CPT Code: 31623
Median Pre-Service Time	20.00	20.00
Median Intra-Service Time	30.00	30.00
Median Immediate Post-service Time	15.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**65.00**	**70.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.66
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.63	3.63
Urgency of medical decision making	3.54	3.42

Technical Skill/Physical Effort (Mean)

Technical skill required	4.19	4.37
Physical effort required	3.26	3.41

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3.48
Outcome depends on the skill and judgment of physician	3.77	4.00
Estimated risk of malpractice suit with poor outcome	3.22	3.44

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.93	2.88
Intra-Service intensity/complexity	3.92	4.04
Post-Service intensity/complexity	2.82	2.85

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey data was collected online with SurveyMonkey. The American Thoracic Society's Clinical Practice ommittee reviewed the data at their July 8, 2005 monthly meeting. The American College of Chest Physicians Practice Management Committee reviewed the data at their July 11, 2005 meeting. Final Consensus was achieved through email confirmation of the completed Summary of Recommendation form. Of the 53% saying that physician work has changed, 87% of those responding to the survey said that the patients are more complex. In addition, the JCAHO regulations for ensuring patient identity and monitoring during the administration of moderate sedation have added to the time of the

procedure. For these reasons, and also because of the increased 5 minutes of physician time and 8 minutes of staff time from the survey results we are requesting a 0.02RVU increase. We did not select the median value because that would create a rank order anomaly to other bronchoscopy codes that have recently been RUC reviewed.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

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ive-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 53% No 47%

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) 87% less complex (less work) 4% no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 4% from inpatient to outpatient 25% no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 31622

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		25	
Clinical Staff #1	Staff Type: RN	Intra Assist Physician Time: 25	Staff % of Physician time 100%
Clinical Staff #2	Staff Type: RN/RT	Intra Assist Physician Time: 17	Staff % of Physician time 68%
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		30		
Clinical Staff #1	Staff Type: RN	Intra Assist Physician Time: 30	Staff % of Physician time 100%	**Change: In Time** 5
Clinical Staff #2	Staff Type: RN/RT	Intra Assist Physician Time: 20	Staff % of Physician time 68%	**Change: In Time** 3
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:33208 Global Period: 090 Specialty Society RVU: **8.12**
RUC RVU: **8.12**

CPT Descriptor: Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year male presented to the emergency room after suddenly losing consciousness while at home. Physical examination was normal except for a pulse rate of 30 bpm and a blood pressure of 76/40. An electrocardiogram demonstrated complete heart block with an atrial rate of 100 bpm and a ventricular rate of 30 bpm with a wide QRS. Insertion of a permanent dual chamber pacemaker system to provide dual chamber physiological pacing is indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 67%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
PRE-SERVICE SURGICAL WORK

- The patient's history and pertinent non-invasive diagnostic studies are reviewed, with special attention to cerebrovascular symptoms, cardiac and other co-morbidities that would place the patient at high risk for surgery.

  Physical exam is reviewed to determine if the patient has had prior procedures that required subclavian vein cannulation, evidence of subclavian vein occlusion, prior mastectomy or breast augmentation and any current central venous lines, rashes or infection.
- Special attention is given to medications, including antiplatelet agents and anticoagulants that the patient may be taking or needs to be taking.
- All pre-procedural blood tests are reviewed, focusing on coagulation and renal function studies. Consideration of renal insufficiency is present, attention is given to whether patient has received appropriate renal protective agents and hydration.
- Based on review of all previous diagnostic studies, the physician estimates the range of introducer sheaths, leads, pacemakers, programmers, pacing system analyzer, external defibrillator and recording equipment that may be required, and ensures that all are available for use.
- Procedure details, including alternatives and risks, are discussed with patient and family. Finally, informed consent is reviewed with patient and family.
- The patient's airway and respiratory status is assessed to evaluate the type of intravenous sedation that is required and safe. If intravenous sedation will not be adequate then general anesthesia support needs to be arranged for and provided.

PRE-SERVICE RADIOLOGICAL SUPERVISION AND INTERPRETATION WORK

- The interventional suite is checked to ensure proper function and configuration of the imaging equipment including compliance with all radiation safety issues.
- The physician ensures that all technical personnel have been familiarized with the pacemaker implantation technique and are fully familiar with all required devices, especially the external defibrillator, recording equipment, programmer and pacing system analyzer. Physician supervises selection of all equipment, including leads, and pacemaker, and assures that all needed equipment is available.
- Prior films/studies are located and reviewed.
- Don radiation protection
- Position (or supervise proper positioning of) patient

CPT Code:

Description of Intra-Service Work:

STERILE PREPARATION AND DRAPING

- Ensure ECG and hemodynamic monitors are in place and functioning
- Light conscious sedation is administered
- Transcutaneous defibrillation patches are positioned
- The physician supervises or preps and drapes the patient for the sterile procedure
- All of the following steps are performed under fluoroscopic guidance

FASHION THE POCKET FOR PULSE GENERATOR

- Direct technical personnel throughout procedure
- Infiltration of the skin inferior to the clavicle with local anesthetic.
- Skin incision and dissection to the pectoralis major fascia with blunt and sharp dissection to produce a pocket.
- Use electrocautery for hemostasis.

VENOUS ACCESS FOR LEAD PLACEMENT

- Under fluoroscopic and anatomic guidance for landmarks, axillary, cephalic or subclavian vein access is obtained usually via needle puncture.
- Care is taken to avoid puncture of the subclavian artery or to enter the pleural space and stay lateral to the subclavius muscle to avoid complications.
- A .035 J-wire is advanced into the vein and positioned in the fight atrium under fluoroscopy.
- The procedure is repeated for the second venous access.

LEAD INSERTION AND POSITIONING UNDER FLUOROSCOPY

- The ventricular lead is introduced into the vein through a peel away introducer.
- The lead stylet is shaped to permit positioning of the lead in the pulmonary artery
- The stylet is exchanged for a straight stylet and then the lead is positioned in the right ventricular apex.
- Lead position is assessed by electrogram morphology, slew rate, pacing impedance, capture thresholds and electrogram amplitude.
- The suture tie down sleeve is positioned and sutured to the lead and the pectoralis major muscle fascia allowing for the appropriate amount of slack in the lead to reduce the likelihood of dislodgement.
- The procedure is repeated for the atrial lead using the remaining guidewire.
- The stylet shapes are quite different in the atrium often requiring more than one shape to provide the optimal location and function of the lead.
- Stimulation of both leads is tested at high output to assure that extracardiac (usually phrenic nerve) stimulation does not occur.

ATTACHMENT OF THE PULSE GENERATOR

- The pocket is inspected for hemostasis and then irrigated with solution.
- The pacemaker is interrogated and programmed to settings appropriate to the underlying conditions of the patient.
- The appropriate leads are put into the pacemaker header and the set screws are tightened.
- The leads are wrapped carefully beneath the pacemaker the generator is placed into the pocket.
- The pocket is closed with at least three layers of suture.
- An appropriate dressing is applied, with consideration for a pressure dressing if anticoagulation is anticipated.
- The pacemaker is reinterrogated to assure that the lead connections are correct and tight.

)escription of Post-Service Work:

- Ensure BP, HR are stable and normal upon arrival to recovery area
- Write post-op orders.
- Communicate with family & referring physicians
- Review results of procedure with patient when sedation wears off
- Dictate procedure note, including interpretation of lead, pulse generator and rhythm status.
- Review, revise, sign final report
- Send formal report to PCP and referring providers
- Review post operative PA and Lateral chest x-ray for lead position
- Review telemetry or holter monitor recordings obtained until discharge
- Prior to discharge test atrial and ventricular sensing and capture function, battery function, pacemaker diagnostics, rate adaptive sensor settings and document the function in a pacemaker follow-up database.
- Check the incision and pocket for bleeding, hematoma, cellulites prior to discharge.
- Discharge day management including communication with PCP, family etc
- Extensive discussions with the patient about timing of follow-up visits, monitoring by remote and in clinic evaluations and the need to keep the incision clean and dry and to report signs of infection.
- All post-procedure outpatient office visits within the global period

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bruce Wilkoff, MD, FACC					
Specialty(s):	American College of Cardiology					
CPT Code:	33208					
Sample Size:	300	**Resp n:** 42		**Response:** 0.00 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		6.00	6.48	**8.50**	10.00	16 24
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**15.0**		
Pre-Service Scrub, Dress, Wait Time:				**15.0**		
Intra-Service Time:		3.00	60.00	**60.00**	90.00	240.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**30.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0** 99239x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 9231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

CPT Code:

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
33240	090	7.59

CPT Descriptor Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
29891	090	8.40

CPT Descriptor 1 Arthroscopy, ankle, surgical; excision of osteochondral defect of talus and/or tibia, including drilling of the defect

MPC CPT Code 2	Global	Work RVU
44950	090	10.00

CPT Descriptor 2 Appendectomy;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 54.7 %

TIME ESTIMATES (Median)	**CPT Code: 33208**	**Key Reference CPT Code: 33240**
Median Pre-Service Time	45.00	38.00
Median Intra-Service Time	60.00	68.00
Median Immediate Post-service Time	30.00	53.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0	0.00
Median Discharge Day Management Time	0	0.00
Median Office Visit Time	0	0.00
Median Total Time	**135**	**174.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.00	3.27
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.45
Urgency of medical decision making	4.00	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.55
Physical effort required	4.00	3.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	2.77
Outcome depends on the skill and judgment of physician	4.00	3.14
Estimated risk of malpractice suit with poor outcome	4.00	3.09

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3.23
Intra-Service intensity/complexity	4.00	3.27
Post-Service intensity/complexity	3.00	2.77

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

n expert consensus panel including members of the American College of Cardiology (ACC) and the Heart Rhythm Society (HRS) teleconferenced to review survey results. The panel first noted that this code was brought to the 5-year review at the request of CMS, not HRS or the ACC. The ACC Cardiovascular Relative Value Update Committee reviewed all cardiology codes in 2004 and did not consider there to be compelling evidence for change in the pacemaker codes based on data available at that time.

The panel first considered the question of whether current RVUs for 33208 are appropriate. The panel considered other RVU's of similar codes (e.g., 33240 need formal descriptor and 33207 need formal descriptor for single chamber pacer) nd by rough estimation of magnitude concluded that a fair value for 33208 relative to other electrophysiology codes would be approximately 10 RVUs. The panel next considered the question of whether there was any compelling evidence for an increase in RVUs for 33208.

The committee noted that the survey median is 8.50, which is .38 RVU above the current value of 8.12. The panel noted that 100% of survey respondents reported that the complexity of patients has increased since the code was last valued 1995. Also, the panel noted that Harvard time for 33208 corresponding to 8.12 RVUs is 215 minutes, and total time from the current survey is 246 minutes. The Panel reviewed IWPUT for 33208 compared to other electrophysiology codes with RUC surveys. The IWPUT for 33208 at 8.12 RVUs is .042. The panel agrees that this is low for a procedure as complex as permanent pacemaker implantation. The panel agreed that by these 4 data points, the current value of 8.12 is undervalued.

After considering all of the above data, the Panel agreed that the current value of 33208 is undervalued. However, the panel agreed that there is not compelling evidence to support a change from this current value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Cardiac fluoroscopy is used to visualize landmarks for vascular access, monitor the passage of the leads to the right atrial and ventricular chambers, visualize the activation of the fixation mechanisms of the leads and monitor for complications such as pneumothorax, hemothorax, pericardial tamponade or passage into incorrect chambers. Control of the Fluoroscopic equipment can be by the implanter or a radiology technician.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

as the work of performing this service changed in the past 5 years? Yes 41% No 59%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 7% I do not agree 93%
B. Patients requiring this service are now:

more complex (more work) 100% less complex (less work) 0% no change 0%

C. The usual site-of-service has changed:
from outpatient to inpatient 0% from inpatient to outpatient 13% no change 87%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 33208

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238: 1 visit @ 36 minutes	
Number and Level of Office Visits:		99211:	
		99212:	
		99213: 1 visit @ 23 minutes	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43235 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **2.39**
RUC RVU: **2.39**

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72 year-old male with weight loss and epigastric pain refractory to pharmacological therapy is referred for esophagogastroduodenoscopy. An esophagogastroduodenoscopy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 93%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: Review with the patient any symptoms and ascertain if dysphagia has been a problem. The patient's history is reviewed to assess for the need for pre-procedure antibiotics. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays are reviewed. The risks and benefits of the procedure are reviewed with the patient and informed consent is obtained.

Description of Intra-Service Work: Intravenous access is started and conscious sedation is administered. A standard upper endoscope is inserted into the mouth and advanced through the esophagus and stomach and through the pylorus into the duodenum. The duodenal mucosa is examined. The endoscope is withdrawn into the stomach and retroflexed to allow examination of the gastric fundus and then straightened to allow examination of the remainder of the gastric mucosa. The endoscope is withdrawn, allowing measurement of the gastro-esophageal junction from the incisors, assess for presence of a hiatal hernia, and then examination of the esophageal mucosa. The endoscope is withdrawn.

Description of Post-Service Work: The patient is transferred to the recovery suite. Post-procedure vital signs are assessed. A procedure report is dictated. When stable for discharge, the findings are reviewed with patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Klaus Mergener, MD, PhD Michael Levy, MD Maurits Wiersema, MD Joel Brill, MD					
Specialty(s):	American Gastroenterological Association American Society for Gastrointestinal Endoscopy					
CPT Code:	43235					
Sample Size:	255	**Resp n:** 61		**Response:** 23.9 %		
ample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.10	2.65	**2.80**	2.87	3.20
Pre-Service Evaluation Time:				**18.0**		

Pre-Service Positioning Time:			**5.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
Intra-Service Time:	5.00	15.00	**20.00**	25.00	55.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
43239	000	2.87

CPT Descriptor Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
52000	000	2.01

CPT Descriptor 1 Cystourethroscopy (separate procedure)

MPC CPT Code 2	Global	Work RVU
31622	000	2.78

CPT Descriptor 2 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)

Other Reference CPT Code	Global	Work RVU
43236	000	2.92

CPT Descriptor Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed submucosal injection(s), any substance

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 58 **% of respondents:** 95.0 %

TIME ESTIMATES (Median)

	CPT Code: 43235	**Key Reference CPT Code: 43239**
Median Pre-Service Time	28.00	27.00
Median Intra-Service Time	20.00	34.00
Median Immediate Post-service Time	15.00	23.50
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**63.00**	**84.50**
ther time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3 62	3.72
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.50
Urgency of medical decision making	3.36	3.43
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.40	3.53
Physical effort required	3.07	3.22
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.05	3.16
Outcome depends on the skill and judgment of physician	3.55	3.62
Estimated risk of malpractice suit with poor outcome	3.60	3.66

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.02	3.07
Intra-Service intensity/complexity	3.21	3.48
Post-Service intensity/complexity	2.97	3.16

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel workgroup from the AGA and the ASGE met and reviewed the survey data. The panel reviewed ne and work value data for other procedures with 0-day global periods, including procedures on the MPC list.

On the basis of the panel's analysis, we are recommending that the current work value of 2.39 for this service is retained. Of note is that this value is substantially lower than both the median RVW and the 25th percentile RVW recommended by the survey participants. While we believe the survey data is reliable, as it is based on a substantial

sample of pediatric and adult gastroenterologists and surgeons practicing in academic, group and independent practice settings throughout the United States, adoption of the survey results would otherwise lead to inconsistencies within the family of EGD codes. Specifically, the code overwhelmingly chosen by the survey participants as the reference procedure, code 43239, EGD with biopsy, has a work value increment of 0.48 over the base EGD code. This ncrement was established by the RUC at the last 5 year review, and we concur that it is appropriate given the higher time and complexity of that procedure. Adoption of the survey RVW recommendation at the median or 25th percentile levels would lessen that differential, and create a rank-order anomaly. Thus, in order to maintain the appropriate relationship of values within the EGD family of procedures, it is our recommendation that the current work value should be maintained.

Over 95% of survey respondents indicated there has been an increase in the complexity of the patients seen over the past 5 years for this procedure. While this can be attributed to a number of factors, including the increasing incidence of elderly patients taking anti-inflammatory and other medications that can have an adverse effect on the gastrointestinal mucosa, the survey respondents noted that they spend increasing amounts of intra-service time monitoring and assessing the patient that has received conscious sedation.

The ASGE and AGA believe a value of 2.39 is reasonable when comparing code 43235 with the value of other 0-day global procedures on the MPC. We have compared this to (1) Code 52000, Diagnostic cystoscopy, with a RVW of 2.01 for 14 minutes of intra time, (2) Code 57410, Pelvic examination under anesthesia, with a RVW of 1.75 for 15 minutes of intra time, and (3) Code 31622, Bronchosopy, with a RVW of 2.78 for 25 minutes of intra time. Only code 31622 is typically performed using conscious sedation.

At the April 2005 meeting, the RUC valued conscious sedation when performed by the same physician at an RVW of 0.66, of which 0.38 was assigned to the intra portion of the service. Using a building block methodology for codes 52000 and 57410, if one adds the RUC approved RVW for the intra service portion of conscious sedation and further adjusts the work value to account for the lesser amount of intra time with these two procedures, the resulting building block values would substantially exceed that of Code 43235. The bronchoscopy procedure is assigned an RVW of 2.78 for a 25 minute procedure. If the RVW was reduced by 20 percent to account for the five less intra service time minutes for Code 43235, the resultant RVW would be 2.23 which is not substantially out of line with the current RVW.

We would also note that Code 31233, Nasal/sinus endoscopy, with maxillary sinusoscopy, has a RVW of 2.18 for 20 minutes of intra time. While this service is not on the MPC, it has been reviewed by the RUC. Sinus endoscopy procedures do not routinely include conscious sedation. . In view of the RUC's recommendations regarding the value assigned to conscious sedation, we believe that the current physician work value assigned to Code 43235 is comparable to the RVW of code 31233 plus the intra-service component of physician work of conscious sedation.

In summary, the panel felt that Code 43235 is reasonably valued in relationship to comparable procedures performed by pulmonologists, urologists, ENT's and gynecologists.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 67% No 33%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 95% less complex (less work) 0% no change 5%
C. The usual site-of-service has changed:
   from outpatient to inpatient 2% from inpatient to outpatient 22% no change 76%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 43235

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		29.00	
Clinical Staff #1	Staff Type: L051A - RN	Intra Assist Physician Time: 25.0	Staff % of Physician time 86%
Clinical Staff #2	Staff Type: L037D - RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time 59%
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		20.0		
Clinical Staff #1	Staff Type: L051A - RN	Intra Assist Physician Time: 17.0	Staff % of Physician time 86%	**Change: In Time** -8.0
Clinical Staff #2	Staff Type: L037D - RN/LPN/MTA	Intra Assist Physician Time: 12.0	Staff % of Physician time 59%	**Change: In Time** -5.0
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43246 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **4.32**
RUC RVU: **4.32**

CPT Descriptor: Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 year old female on chronic anticoagulation for atrial fibrillation with congestive heart failure has recently suffered a stroke. A swallowing study shows impaired swallowing with aspiration. Esophagogastroduoendoscopy with percutaneous endoscopic gastrostomy tube placement is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 89%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: Review with the patient any symptoms. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays are reviewed. The risks and benefits of the procedure are reviewed with the patient and informed consent is obtained.

Description of Intra-Service Work: Intravenous access is started. Antiobiotics are administered. Conscious sedation is administered. A standard upper endoscope is inserted into the mouth and advanced through the esophagus and stomach and through the pylorus into the duodenum. The duodenal mucosa is examined. The endoscope is withdrawn into the stomach and retroflexed to allow examination of the gastric fundus and then straightened to allow examination of the remainder of the gastric mucosa. The stomach is insufflated with air until trans-illumination allows external visualization on the upper abdominal wall of the endoscope light. The abdomen site is prepped with bactericidal solution. A finger is pressed on the abdominal wall site to endoscopically confirm apposition of the stomach against the abdominal wall. Local anesthestic is infiltrated into the subcutaneous and intramuscular portions of the abdomen site, and a scapel is used to make an incision in the abdominal wall. A gastrostomy introducer catheter is introduced through the incision into the stomach. A snare is introduced through the endoscope and looped around the catheter. The catheter introducer needle is withdrawn and a guide wire is passed externally through the introducer into the stomach. The snare is tightened around the guide wire, and the endoscope, snare and guidewire are withdrawn through the mouth. The guide wire is removed from the endoscope. A percutaneous gastrostomy is passed over the guide wire through the mouth and pushed until it exits through the abdominal wall incision. The gastrostomy is gently pulled until resistance is felt. The endoscope is introduced through the mouth into the stomach to confirm positioning of the internal bolster of the gastrostomy against the stomach wall. An external bolster is slipped over the guidewire and introducer to position the gastrostomy in place. The guide wire is removed. Air is suctioned from the stomach, and the endoscope is removed. The abdominal site is cleaned, bandaged and dressed.

Description of Post-Service Work: The patient is transferred to the recovery suite. Post-procedure vital signs are assessed. A procedure report is dictated. When stable for discharge, the findings are reviewed with patient and family.

URVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005

Presenter(s):	Klaus Mergener, MD, PhD Michael Levy, MD Maurits Wiersema, MD Joel V. Brill, MD
Specialty(s):	American Gastroenterological Assocation (AGA) American Society for Gastrointestinal Endoscopy (ASGE)
CPT Code:	43246

Sample Size:	255	**Resp n:** 56	**Response:** 21.9 %
Sample Type:	Convenience		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	3.05	4.50	**4.80**	5.07	7.00
Pre-Service Evaluation Time:			**35.0**		
Pre-Service Positioning Time:			**8.0**		
Pre-Service Scrub, Dress, Wait Time:			**5.0**		
Intra-Service Time:	10.00	25.00	**38.00**	40.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**20.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3244	000	5.04

CPT Descriptor Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with band ligation of the esophageal and/or gastric varices.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
52275	000	4.69

CPT Descriptor 1 Cystourethroscopy, with internal urethrotomy; male

MPC CPT Code 2	Global	Work RVU
93508	000	4.09

CPT Descriptor 2 Catheter placement on coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization.

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 50 **% of respondents:** 89.2 %

TIME ESTIMATES (Median)

	CPT Code: 43246	**Key Reference CPT Code: 43244**
Median Pre-Service Time	48.00	57.00
Median Intra-Service Time	38.00	54.00
Median Immediate Post-service Time	20.00	36.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**106.00**	**147.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.68	4.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.24	4.36
Urgency of medical decision making	3.60	4.56

Technical Skill/Physical Effort (Mean)

Technical skill required	4.64	4.68
Physical effort required	4.52	4.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.68	4.68
Outcome depends on the skill and judgment of physician	4.64	4.72
Estimated risk of malpractice suit with poor outcome	4.44	4.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.40	4.48
Intra-Service intensity/complexity	4.60	4.60
Post-Service intensity/complexity	4.04	4.08

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel workgroup from the AGA and the ASGE met and reviewed the survey data. The panel reviewed me and work value data for other procedures with 0-day global periods, including procedures on the MPC list.

On the basis of the panel's analysis, we are recommending that the current work value of 4.32 is retained. Of note is that this value is substantially lower than the median and 25th percentile RVW recommended by the survey participants. Percutaneous endoscopic placement of a gastrostomy is a very complex service which frequently involves use of a co

surgeon. The ASGE and AGA recognize that when calculated with the current RVW and the median time data, the IWPUT for this procedure of 0.095 is higher than most endoscopy procedures. However, our specialty consensus panel recognized that the difficulty and stress of performing this procedure, particularly when performed by a single physician, justifies this level of intensity. We note that use of a co-surgeon would add 25 percent to the total payment, as both co-surgeons are required to bill using modifier 62.

Moreover, after reviewing the survey data, it was the consensus panel's judgment that many of the survey respondents substantially underestimated the intra service time for performing this service. The AGA and ASGE believe that 40 minutes of intra-service time is a more accurate figure for performing this service when a co-surgeon is not involved. This is the more typical case, as evidenced by the survey respondents, and is consistent with the intra service time estimate at the 75th percentile of survey responses. Use of the 40 minute recommendation would reduce the IWPUT to 0.071, which would not trigger a rank order anomaly.

In comparing this procedure to other 0-day procedures of high complexity, we note the following procedures on the MPC that have been reviewed by the RUC, each of which involving 30 minutes of intra time. Code 52276, Cytourethroscopy, with direct vision internal urethrotomy involves 30 minutes of intra time with a RVW of 4.99. Code 93508, Catheter placement in coronary artery(s) for coronary angiography without concomitant left heart catheterization, involves 30 minutes of intra time with a RVW of 4.09. We note that conscious sedation is an inherent component of code 93508.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 68% No 32%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 11% I do not agree 89%
B. Patients requiring this service are now:
   more complex (more work) 97% less complex (less work) 0% no change 3%

C. The usual site-of-service has changed:
from outpatient to inpatient 0% from inpatient to outpatient 8% no change 92%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 43246

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		0.00	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		0.0	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:43750 | Global Period: 010 | **Recommended Work Relative Value** Specialty Society RVU: **5.0** RUC RVU: **4.48**

CPT Descriptor: Percutaneous placement of gastrostomy tube

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female presented with a massive CVA and inability to take oral nutrition. The patient is malnourished and needs enteral nutritional support. The decision is made to perform a percutaneous feeding gastrostomy.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work:
Pre-service work begins after the decision to operate is made and until the time of the procedure.

The physician:

- Reviews the previous medical history, lab reports, and prior imaging studies
- Consults with the referring physician and other health care professionals
  Explains the procedure to the patient and his/her family
- Obtains informed consent
- Scrubs and dons protective gear
- Supervises the preparation of the imaging equipment and supplies
- Supervises the positioning, prepping, and draping of the patient

Description of Intra-Service Work:
The physician:

- Performs fluoroscopy of the upper abdomen to ensure that no colon or abdominal viscera are juxtaposed between skin and stomach [Imaging guidance is separately reportable using code 74350.]
- Inserts a nasogastric tube for gastric insufflation if one has not been previously placed
- Administers local anesthesia for pain control
- Marks the location of puncture over the gastric body
- Places 2-3 suture anchors through the skin into the stomach (pushing the T-bar anchor out of the needle with a wire) and apposes the gastric wall to the anterior abdominal wall.
- Makes a skin incision over the intended puncture site
- Introduces a 9cm, 18-gauge Seldinger entry needle through the incision and into the stomach under imaging guidance [Imaging guidance is separately reportable using code 74350.]
- Advances a heavy-duty J-wire through the 18 gauge needle into the stomach
- Dilates the tract with sequential dilators advanced over the wire
- Introduces a peel-away sheath
- Introduces large-bore gastrostomy catheter through the peelaway sheath into the stomach and secures the ıtheter against the gastric wall
- Applies anchoring sutures and catheter-anchoring device
- Applies sterile dressing

Description of Post-Service Work:

The physician:

- Monitors patient's stability in recovery room
- Writes orders for pain/medical management and enteral feedings
  Dictates and reviews procedural report
- Communicates with patient's family
- Communicates with referring physician
- Rounds on the patient while on floor, if necessary
- Provides discharge management including examination and instructions
- Sees patient in office, if necessary, within 10 days following the procedure for suture removal, wound care, etc.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., MD, American College of Radiology Zachary Rattner, MD, Society of Interventional Radiology Robert L. Vogelzang, MD, Society of Interventional Radiology					
Specialty(s):	American College of Radiology Society of Interventional Radiology					
CPT Code:	43750					
Sample Size:	398	**Resp n:** 57		**Response:** 14.32 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		2.00	5.00	**6.00**	8.00	10.00
Pre-Service Evaluation Time:				**16.0**		
re-Service Positioning Time:				**10.0**		
Pre-Service Scrub, Dress, Wait Time:				**10.0**		
Intra-Service Time:		15.00	30.00	**30.00**	48.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**15.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**19.0**	99231x **1.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**15.0**	99211x **0.0** 12x **1.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).



KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
36558	010	4.79

CPT Descriptor Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
38510	010	6.42

CPT Descriptor 1 Biopsy or excision of lymph node(s); open, deep cervical node(s)

MPC CPT Code 2	Global	Work RVU
20103	010	5.29

CPT Descriptor 2 Exploration of penetrating wound (separate procedure); extremity

Other Reference CPT Code	Global	Work RVU
37183	000	7.99

CPT Descriptor Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance and documentation)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 26.3 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 43750	Key Reference CPT Code: 36558
Median Pre-Service Time	36.00	36.00
Median Intra-Service Time	30.00	30.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	19.0	0.00
Median Discharge Day Management Time	0.0	18.00
Median Office Visit Time	15.0	15.00
Median Total Time	**115.00**	**114.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.07	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.27	2.13
Urgency of medical decision making	1.87	1.93

Technical Skill/Physical Effort (Mean)

Technical skill required	2.86	2.93
Physical effort required	2.73	2.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.93	2.60
Outcome depends on the skill and judgment of physician	3.00	2.93
Estimated risk of malpractice suit with poor outcome	2.60	2.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.20	2.20
Intra-Service intensity/complexity	2.93	2.47
Post-Service intensity/complexity	2.00	1.60

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ode 43750 was identified for the 5YR by CMS because, "the largest number of services were selected for review because they have never been reviewed by the RUC (that is, Harvard RVUs are still being used, or there is no information)."

Our survey shows that the Harvard time underestimated total time, particularly in the post-procedure environment for this 10-day global code.

The current 5YR survey times/visits and median RVW of 6.00 suggest that 43750 with a current RVW= 4.48 is undervalued. However, from the first 5YR in 1995, the RUC indicated that code 43750 should have an IWPUT that is lower than that for code 43830 (Revision of gastroduodenal anastomosis (gastroduodenostomy) with reconstruction; without vagotomy) which has an IWPUT of 0.059. Therefore, an IWPUT of 0.078 for the median RVW from our current survey is at odds with the RUC's previous recommendation with respect to code 43830. If we consider the survey 25th percentile RVW of 5.00, the IWPUT is 0.045 which is a value less than 0.059 as previously discussed at the RUC. IWPUT analysis for both the median and 25th pctl are presented below.

We recommend the survey 25th percentile RVW of 5.00 for 43750.

IWPUT Survey CPT code: 43750
ANALYSIS
Median Svy: 6.00

	Survey Data Time	RUC Standard Intensity	RVW (=time x intensity)	
Pre-service				
Pre-service eval & positioning	40	0.0224	0.896	
Pre-service scrub, dress, wait	10	0.0081	0.081	
Pre-service total			0.977	
Post-service	Time	Intensity	(=time x intensity)	
Immediate post	15	0.0224	0.336	
Subsequent visits:	Visit n.	E/M	RVW	
99231	1	0.64	0.64	
Discharge 99238	1	1.28		1.28
99212	1	0.43		0.43
Post-service total			2.686	
	Time	IWPUT	INTRA-RVW	
Intra-service:	30	0.078	2.34	

IWPUT Survey CPT code: 43750
ANALYSIS
Median Svy: 5.00

	Survey Data Time	RUC Standard Intensity	RVW (=time x intensity)	
Pre-service				
Pre-service eval & positioning	40	0.0224	0.896	
Pre-service scrub, dress, wait	10	0.0081	0.081	
Pre-service total			0.977	
Post-service	Time	Intensity	(=time x intensity)	
Immediate post	15	0.0224	0.336	
Subsequent visits:	Visit n	E/M	RVW	
99231	1	0.64	0.64	
Discharge 99238	1	1.28		1.28
99212	1	0.43		0.43
Post-service total			2.686	
	Time	IWPUT	INTRA-RVW	
Intra-service:	30	0.0445	2.337	

In comparison to the key reference code 36558 (Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older), the recommended RVW correctly accounts for additional post-service work. Patients receiving g-tubes are typically inpatient, while CVA patients are outpatient.

The recommended RVW for code 43750 (5.00) compares favorably to MPC code 38510 (Biopsy or excision of lymph node(s); open, deep cervical node(s)). First, both codes are 10-day globals. Next, the two codes have comparable pre-service time (50 minutes for 43750 vs. 45 minutes for 38510). Code 43750 has more total post-service time than 38510 (85 minutes vs. 61 minutes). However, code 38510 has more intraservice time (45 minutes) than code 43750 (30 ninutes), which contributes to a higher IWPUT for 38510 (0.081 vs. 0.045). In total, the combination of greater pre-time and post-time for code 43750 results in more total time than that for code 38510 -- 165 minutes vs. 151 minutes, respectively.

Another relevent MPC comparison is code 20103 (Exploration of penetrating wound (separate procedure); extremity). Code 20103 has more intraservice time (60 minutes) than code 43750 (30 minutes), but code 43750 has more total physician time 165 minutes vs. 135 minutes. Also, code 20103's IWPUT (0.059) compares favorably with code 43750 (0.045).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☒ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Code	Global	RVW	Pre-	Intra-	Post-	Total
47350	010	5.00				165 minutes
74350	XXX	0.76				16 minutes
		5.76				181 minutes

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 13% No 87%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 18% I do not agree 82%
B. Patients requiring this service are now:
   more complex (more work) 38% less complex (less work) 17% no change 45%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 34% no change 66%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:45330 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **1.10**
RUC RVU: **0.96**

CPT Descriptor: Sigmoidoscopy, flexible;diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64 year-old male underwent colonoscopy 6 months earlier at which time a 2 cm sessile adenomatous polyp was removed from the descending colon. Flexible sigmoidoscopy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 45%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review with the patient any symptoms. The patient's history is reviewed to assess for the need for pre-procedure antibiotics. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays are reviewed. The risks and benefits of the procedure are reviewed with the patient and informed consent is obtained.

Description of Intra-Service Work: A standard flexible sigmoidoscope is inserted into the rectum and advanced through the sigmoid colon to the splenic flexure. The sigmoidoscope is withdrawn to allow examination of the colon mucosa. In the rectum, the sigmoidoscope is retroflexed to allow examination of the rectal mucosa, and then straightened and withdrawn.

Description of Post-Service Work: The patient is transferred to the recovery suite. Post-procedure vital signs are assessed. A procedure report is dictated. When stable for discharge, the findings are reviewed with patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Klaus Mergener, MD, PhD Michael Levy, MD Maurits Wiersema, MD Joel V. Brill, MD					
Specialty(s):	American Gastroenterological Assocation (AGA) American Society for Gastrointestinal Endoscopy (ASGE)					
CPT Code:	45330					
Sample Size:	0	**Resp n:** 0		**Response:** 0.0 %		
Sample Type:						
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:						
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:				**0.00**		

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
45331	000	1.15

CPT Descriptor Sigmoidoscopy, flexible; diagnostic, with biopsy, single or multiple.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
52000	000	2.01

CPT Descriptor 1 Cystourethroscopy (separate procedure)

MPC CPT Code 2	Global	Work RVU
31575	000	1.10

CPT Descriptor 2 Laryngoscopy, flexible fiberoptic; diagnostic

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 56 **% of respondents:** 91.8 %

TIME ESTIMATES (Median)

	CPT Code: 45330	Key Reference CPT Code: 45331
Median Pre-Service Time	0.00	25.00
Median Intra-Service Time	0.00	15.00
Median Immediate Post-service Time	0.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**0.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.70	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.79
Urgency of medical decision making	2.64	2.68

Technical Skill/Physical Effort (Mean)

Technical skill required	2.93	3.02
Physical effort required	2.77	2.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.59	2.68
Outcome depends on the skill and judgment of physician	3.14	3.18
Estimated risk of malpractice suit with poor outcome	3.43	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.63	2.63
Intra-Service intensity/complexity	2.79	3.00
Post-Service intensity/complexity	2.68	2.77

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

consensus panel workgroup from the AGA and the ASGE met and reviewed the survey data. The panel reviewed .ne and work value data for other procedures with 0-day global periods, including procedures on the MPC list.

On the basis of the panel's analysis, we are recommending an RVW of 1.10, consistent with the median survey values. This would result in an IWPUT of 0.026. There has been a dramatic reduction in the volume of sigmoidscopy procedures in recent years. Since colonoscopy has become the procedure of choice for both diagnostic and screening

purposes, flexible sigmoidoscopy is largely reserved for patients who cannot tolerate a colonoscopy because of anatomic blockage, an inability to tolerate anesthesia, or other clinical reason. We note that two-thirds of the survey participants indicated that patients who receive this service have become more complex in the last 5 years. However, the movement away from the rigid and flexible sigmoidoscopy procedures began more than 5 years ago. The RUC data base indicates hat in 1993 there were 777,000 flexible sigmoidoscopy procedures as compared with 148,000 in 2003. Thus, the survey responses may have underestimated the change in patient complexity that occurred since the service was valued by Harvard since the question was limited to the last 5 years.

The ASGE and AGA recognize that acceptance of the recommended RVW would result in a narrowing of the work value increments for other codes in the flexible sigmoidoscopy family of procedures. For example, the RVW for Code 45331, flexible sigmoidoscopy with biopsy, is 1.15. If our recommendation is accepted by the RUC, this would lessen the increment for the biopsy to 0.05 RVUs. Thus, if our recommendation is accepted, we believe there may be a need to review this entire family of codes at some point in the future to prevent rank order anomalies.

In terms of comparing this code with other 0-day global procedures, we would compare flexible sigmoidoscopy to the following services on the MPC list that have been reviewed by the RUC. Code 52000, diagnostic cystoscopy, has a RVW of 2.01 with 14 minutes of intra time. Code 31575, Diagnostic Laryngoscopy, has a RVW of 1.10 with 14 minutes of intra time. We believe our recommendation for flexible sigmoidoscopy is consistent to these other procedures of similar time, physician work and intensity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 15% No 45%

Jse the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 100% I do not agree 0%
B. Patients requiring this service are now:
   more complex (more work) 81% less complex (less work) 0% no change 19%

C. The usual site-of-service has changed:
from outpatient to inpatient 0% from inpatient to outpatient 25% no change 75%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 45330

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		17.00	
Clinical Staff #1	Staff Type: L037D - RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		17.0		
Clinical Staff #1	Staff Type: L037D - RN/LPN/MTA	Intra Assist Physician Time: 17.0	Staff % of Physician time **Time** 100%	**Change: In** 0.0
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:45378 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **3.69**
RUC RVU: **3.69**

CPT Descriptor: 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)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67 year-old woman is found to have heme positive stool with a hemoglobin of 11.5 gms/dl and an MCV of 78. She denies any abdominal symptoms. Colonoscopy is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Is conscious sedation inherent to this procedure? Yes Percent of survey respondents who stated it is typical? 89%

Is conscious sedation inherent in your reference code? Yes

Description of Pre-Service Work: Review with the patient any symptoms. The patient's history is reviewed to assess for the need for pre-procedure antibiotics. A review of the patient's allergies and medications is done specifically noting usage of antiplatelet or anticoagulation medications. A pre-anesthetic exam with airway assessment and cardiopulmonary evaluation is performed. The patient's laboratory studies as they relate to coagulation status and the platelet count are reviewed. The patient's x-rays are reviewed. The risks and benefits of the procedure are reviewed with the patient and informed consent is obtained.

Description of Intra-Service Work: Intravenous access is started and conscious sedation is administered. A standard colonoscope is inserted into the rectum and advanced to the cecum. The ileo-cecal valve is identified, and the terminal ileum is intubated. The colonoscope is withdrawn through the ascending colon, hepatic flexure, transverse colon, splenic flexure, and sigmoid colon to allow examination of the colon mucosa. In the rectum, the colonoscope is retroflexed to allow examination of the rectal mucosa, and then straightened and withdrawn.

Description of Post-Service Work: The patient is transferred to the recovery suite. Post-procedure vital signs are assessed. A procedure report is dictated. When stable for discharge, the findings are reviewed with patient and family.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Klaus Mergener, MD, PhD Michael Levy, MD Maurits Wiersema, MD Joel Brill, MD					
Specialty(s):	American Gastroenterological Association American Society for Gastrointestinal Endoscopy					
CPT Code:	45378					
Sample Size:	255	**Resp n:** 61		**Response:** 23.9 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		3.60	4.25	**4.36**	4.45	5.00
Pre-Service Evaluation Time:				**20.0**		
Pre-Service Positioning Time:				**5.0**		

Pre-Service Scrub, Dress, Wait Time:				5.0		
Intra-Service Time:		15.00	28.00	**30.00**	40.00	50.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**15.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit. 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
45380	000	4.43

CPT Descriptor Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
31622	000	2.78

CPT Descriptor 1 Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)

MPC CPT Code 2	Global	Work RVU
93508	000	4.09

CPT Descriptor 2 Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization

Other Reference CPT Code	Global	Work RVU
43258	000	4.54

CPT Descriptor Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 59 **% of respondents:** 96.7 %

TIME ESTIMATES (Median)	**CPT Code: 45378**	**Key Reference CPT Code: 45380**
Median Pre-Service Time	30.00	45.00
Median Intra-Service Time	30.00	51.50
Median Immediate Post-service Time	15.00	22.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**75.00**	**118.50**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.92	4.03
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.64	3.73
Urgency of medical decision making	3.73	3.83

Technical Skill/Physical Effort (Mean)

Technical skill required	4.32	4.39
Physical effort required	4.17	4.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.10	4.19
Outcome depends on the skill and judgment of physician	4.44	4.47
Estimated risk of malpractice suit with poor outcome	4.47	4.53

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.42	3.44
Intra-Service intensity/complexity	4.02	4.10
Post-Service intensity/complexity	3.61	3.68

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A consensus panel workgroup from the AGA and the ASGE met and reviewed the survey data. The panel reviewed time and work value data for other procedures with 0-day global periods, including procedures on the MPC list.

On the basis of the panel's analysis, we are recommending that the current work value of 3.69 for this service is retained. Of note is that this value is substantially lower than both the median RVW and the 25th percentile RVW recommended by the survey participants. While we believe the survey data is reliable as it is based on a substantial

sample of pediatric and adult gastroenterologists and surgeons practicing in academic, group and independent practice settings throughout the United States, adoption of the survey results would otherwise lead to inconsistencies within the family of other endoscopy codes within the colonoscopy family of procedures.

The ASGE and AGA believe a value of 3.69 is reasonable when comparing code 45378 with the value of other 0-day global procedures on the MPC. We would note the following codes on the MPC list that have been reviewed by the RUC, which include conscious sedation. Code 93508, Catheter placement in coronary artery(s) for coronary angiography without concomitant left heart catheterization, has a RVW of 4.09 with 30 minutes of intra time. Code 31622, Bronchosocopy, rigid or flexible, with or without fluoroscopic guidance, diagnostic, has a RVW of 2.78 with 25 minutes of intra time. Extrapolating code 31622 to a 30 minute procedure would result in an RVW slightly lower than the current value. However, we believe the considerably greater diagnostic complexity of a colonoscopy as compared to a diagnostic bronchoscopy would justify a higher IWPUT for the colonoscopy procedure.

We note that Code 31233, Nasal/sinus endoscopy, with maxillary sinusoscopy, has a RVW of 2.18 with 20 minutes of intra time. While this service is not on the MPC, it has been reviewed by the RUC. If one were to extrapolate the 2.18 RVW for a 20 minute procedure to an equivalently valued 30 minute procedure, this would result in an RVW of 3.27. Furthermore, these sinus endoscopy procedures do not typically include conscious sedation. At the April 2005 meeting, the RUC valued conscious sedation when performed by the same physician at a RVW of 0.66 of which 0.38 was assigned to the intra-service portion. Given the value of physician work that the RUC has assigned to conscious sedation when provided by the same physician performing the procedure, our consensus panel believes the work value assigned to Code 45378 is comparable to the RVW assigned to the sinus endoscopy code after adjusting for the difference in intra time and accounting for the work involved in performing conscious sedation.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 62% No 36%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):

I agree 8% I do not agree 92%

B. Patients requiring this service are now:
more complex (more work) 89% less complex (less work) 0% no change 11%

C. The usual site-of-service has changed:
from outpatient to inpatient 0% from inpatient to outpatient 34% no change 66%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 45378

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		39.00	
Clinical Staff #1	Staff Type: L051A - RN	Intra Assist Physician Time: 39.0	Staff % of Physician time 100%
Clinical Staff #2	Staff Type: L037D - RN/LPN/MTA	Intra Assist Physician Time: 26.0	Staff % of Physician time 67%
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:		30.0		
Clinical Staff #1	Staff Type: L051A - RN	Intra Assist Physician Time: 30.0	Staff % of Physician time 100%	**Change: In Time** -9.0
Clinical Staff #2	Staff Type: L037D - RN/LPN/MTA	Intra Assist Physician Time: 20.0	Staff % of Physician time 67%	**Change: In Time** -6.0
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:62270 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **1.65**
RUC RVU: **1.37**

CPT Descriptor: Spinal puncture, lumbar diagnostic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents with fever, severe headache, and neck stiffness. A lumbar puncture is indicated to evaluate for possible meningitis and other appropriate evaluations are completed. The risks and benefits of a lumbar puncture are reviewed, the procedure is described, and informed consent is obtained. The patient is placed on a monitoring device, positioned, and immobilized as necessary. The lumbar puncture is completed using sterile technique after administration of local anesthesia.

Percentage of Survey Respondents who found Vignette to be Typical: 65%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 13%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The risks and benefits of recommended lumbar puncture are reviewed. Informed consent is obtained.

Description of Intra-Service Work: The patient is placed on a monitoring device, positioned, and restrained as necessary. The lumbar spine is prepared using provodine iodine. The area for the lumbar puncture is determined by palpitation and anesthetized using 1.0% xylocaine, changing needles for deeper infiltration. A spinal needle is inserted and advanced until cerebrospinal fluid is obtained. A pressure gauge is attached to the spinal needle. Cerebrospinal fluid samples are obtained in sterile tubes to be sent for analysis. The needle is then withdrawn and direct pressure applied for one minute. A bandage is applied and the patient placed on his/her back.

Description of Post-Service Work: The patient is observed for any post-operative complications and the patient/family counseled about possible headaches and their management. Post-procedural spinal headache is treated as necessary. The detailed procedural note is completed and orders written directing analysis of the cerebrospinal samples obtained.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Steve Krug, MD, Jim Anthony, MD, and Marc Raphaelson, MD					
Specialty(s):	American Academy of Pediatrics and American Academy of Neurology					
CPT Code:	62270					
Sample Size:	53	**Resp n:** 31		**Response:** 58.4 %		
Sample Type:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.85	1.50	**1.65**	1.92	2.40	
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**5.0**			
Pre-Service Scrub, Dress, Wait Time:			**5.0**			
Intra-Service Time:	10.00	15.00	**20.00**	20.00	35.00	

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
32000	000	1.54

CPT Descriptor Thoracentesis

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95180	000	2.01

CPT Descriptor 1 Rapid desensitization procedure, each hour (eg, insulin, penicillin, equine serum)

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
36660	000	1.40

CPT Descriptor Catheterization, umbilical artery, newborn, for diagnosis or therapy

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 54.8 %

TIME ESTIMATES (Median)

	CPT Code: 62270	Key Reference CPT Code: 32000
Median Pre-Service Time	10.00	10.00
Median Intra-Service Time	20.00	28.00
Median Immediate Post-service Time	10.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**40.00**	**48.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.38	3.15
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.08	4.04
Urgency of medical decision making	3.04	3.12

Technical Skill/Physical Effort (Mean)

Technical skill required	4.19	3.54
Physical effort required	3.88	3.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.27	3.96
Outcome depends on the skill and judgment of physician	4.15	4.19
Estimated risk of malpractice suit with poor outcome	3.31	3.12

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.73	3.69
Intra-Service intensity/complexity	4.00	4.12
Post-Service intensity/complexity	3.96	3.77

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel consisting of members of the American Academy of Pediatrics (AAP) and the American Academy of eurology (AAN) reviewed the survey results. Based on the consistency of the survey data, they recommend the survey median of 1.65 work RVUs.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 77% No 33%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 35% I do not agree 65%
B. Patients requiring this service are now:
   more complex (more work) 81% less complex (less work) 6% no change 13%
C. The usual site-of-service has changed:
   from outpatient to inpatient 3% from inpatient to outpatient 23% no change 74%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 62270

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:70355 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **.22**
RUC RVU: **.20**

CPT Descriptor: Orthopanogram

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male presents to the office upon referral by the emergency room physician after having sustained multiple blows to the face and head during interpersonal violence. There was no loss of consciousness. The patient is complaining of numbness under the left eye and left chin regions, in addition to pain when attempting to close his mouth. He presents with radiographs taken while at the emergency room and a note from the emergency room physician indicating that there are "questionable" facial fractures. After the technician has completed taking and developing the orthopantomogram, the physician interprets the orthopantomogram.

Percentage of Survey Respondents who found Vignette to be Typical: 46%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Review of the clinical history will be included in a separately billed evaluation and management code.

Description of Intra-Service Work: After the technician has completed taking and developing orthopantomogram, the physician interprets the orthopantomogram for integrity of right and left temporomandibular joints, right and left glenoid fossae, right and left zygoma, right and left coronoid processes, right and left infra-orbital rims, maxilla, mandible and dentition. Correlate findings to clinical exam findings.

Description of Post-Service Work: Document findings and conduct telephone consultation with referring doctor.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Timothy S. Shahbazian, DDS					
Specialty(s):	Oral and Maxillofacial Surgery					
CPT Code:	70355					
Sample Size:	1400	**Resp n:** 39		**Response:** 2.7 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.15	0.20	**0.22**	0.30	2.00
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		0.00	1.00	**5.00**	5.00	25.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**1.00**					

CPT Code:

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
'0140	XXX	0.19

CPT Descriptor Radiologic examination, facial bones; less than three views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	.17

CPT Descriptor 1 Radiolgic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU
71020	XXX	.22

CPT Descriptor 2 Radiologic examination, chest, two views, frontal and lateral;

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 38.4 %

TIME ESTIMATES (Median)

	CPT Code: 70355	**Key Reference CPT Code: 70140**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	5.00	6.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**6.00**	**6.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.53	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.07	3.00
Urgency of medical decision making	3.40	3.36

Technical Skill/Physical Effort (Mean)

Technical skill required	2.80	2.86
Physical effort required	1.73	1.64

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	2.64
Outcome depends on the skill and judgment of physician	2.53	3.50
Estimated risk of malpractice suit with poor outcome	3.47	3.43

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.93	1.86
Intra-Service intensity/complexity	2.33	2.43
Post-Service intensity/complexity	2.27	2.21

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Non-surveyed Harvard data show a total physician time of 8 minutes. The currently surveyed data show pre-, intra-, and post-service physician times of 4, 5, and 5 minutes respectively. The survey instrument stated "do not include evaluation and management services provided in addition to the service you are rating." as this would be caputred by a separetely billable E&M code. The survey results justify a total physician time of 10 minutes (5 minutes for intra-service physician time and 5 minutes for post-service physician time).

SERVICES REPORTED WITH MULTIPLE CPT CODES

. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 13% No 87%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 40% I do not agree 60%
B. Patients requiring this service are now:
   more complex (more work) 40% less complex (less work) no change 60%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 40% no change 60%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 70355

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:71010 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.18**
RUC RVU: **0.18**

CPT Descriptor: Radiologic examination, chest; single view, frontal

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old male with unstable angina and pulmonary edema underwent emergency coronary artery bypass grafting. Immediately post-operatively the patient is hypoxemic with decreased breath sounds on the left. A portable AP chest radiograph is ordered in the recovery room.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:
- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.					
Specialty(s):	American College of Radiology					
CPT Code:	71010					
Sample Size: 369	**Resp n:** 104	**Response:** 28.18 %				
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.12	0.20	**0.24**	0.30	2.00	
Pre-Service Evaluation Time:			**1.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	1.00	2.00	**3.00**	4.00	10.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
72100	XXX	0.22

CPT Descriptor Radiologic examination, spine, lumbosacral;two or three views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU
74400	XXX	0.49

CPT Descriptor 2 Urography (pyelography), intravenous, with or without KUB, with or without tomography

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 33.6 %

TIME ESTIMATES (Median)

	CPT Code: 71010	Key Reference CPT Code: 72100
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	**0.00**
Other time if appropriate		6.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.09	2.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	2.15
Urgency of medical decision making	3.59	2.24

Technical Skill/Physical Effort (Mean)

Technical skill required	2.44	2.26
Physical effort required	1.74	1.74

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.09	2.24
Outcome depends on the skill and judgment of physician	3.41	2.56
Estimated risk of malpractice suit with poor outcome	3.38	2.62

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.90	1.60
Intra-Service intensity/complexity	2.71	2.32
Post-Service intensity/complexity	1.93	1.70

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR RUC Committee reviewed the survey data and concluded there is no compelling evidence to change the work VU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 19% No 81%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 25% I do not agree 75%
B. Patients requiring this service are now:
   more complex (more work) 80% less complex (less work) no change 20%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 10% no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:71020 Global Period: XXX Specialty Society RVU: **0.22**
RUC RVU: **0.22**

CPT Descriptor: Radiologic examination, chest, two views, frontal and lateral;

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70 year old with stage 4 breast cancer and known pleural and pulmonary metastases presents to her physician with new onset dyspnea and fever. PA and lateral chest radiographs are ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:
- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.					
Specialty(s):	American College of Radiology					
CPT Code:	71020					
Sample Size:	369	**Resp n:** 104		**Response:** 28.18 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.16	0.23	**0.30**	0.33	1.50
Pre-Service Evaluation Time:				**1.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		1.00	3.00	**3.00**	5.00	10.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit. 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
72100	XXX	0.22

CPT Descriptor Radiologic examination, spine, lumbosacral; two or three views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU
74400	XXX	0.49

CPT Descriptor 2 Urography (pyelography), intravenous, with or without KUB, with or without tomography

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 38 **% of respondents:** 36.5 %

TIME ESTIMATES (Median)	**CPT Code: 71020**	**Key Reference CPT Code: 72100**
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	
Other time if appropriate		6 (H)

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.32	2.99
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	2.29
Urgency of medical decision making	3.13	2.34

Technical Skill/Physical Effort (Mean)

Technical skill required	2.47	2.29
Physical effort required	1.74	1.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.08	2.23
Outcome depends on the skill and judgment of physician	3.61	2.77
Estimated risk of malpractice suit with poor outcome	3.58	2.69

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.92	1.65
Intra-Service intensity/complexity	2.87	2.44
Post-Service intensity/complexity	2.11	1.63

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR RUC Committee reviewed the survey data and concluded there is no compelling evidence to change the work VU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 16% No 84%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 20% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
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CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:71260 Global Period: XXX Specialty Society RVU: **1.30**
RUC RVU: **1.24**

CPT Descriptor: Computed tomography, thorax; with contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old male with a history of lung cancer was treated with radiation and right upper lobectomy. Six months later he presents to his physician with recurrent cough. Chest radiographs demonstrate mediastinal widening and new interstitial opacities on the left. A contrast enhanced CT of the chest is ordered.

(Note: Three-dimensional rendering, if ordered and performed, is coded separately. However, per CPT 2006, interpretation of two-dimensional thin section coronal and/or sagittal reformatted images is now included with 71260.)

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior imaging studies
- Determine the appropriate CT protocol for the examination and communicate that protocol to the CT technologists

Description of Intra-Service Work:
- Review and interpret scout radiographs
- Supervise administration of intravenous contrast
- Review initial and subsequent series of CT image data to assure adequacy of anatomic coverage and assess need for repeat sections
- Interpret the examination and compare to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M D.					
Specialty(s):	American College of Radiology					
CPT Code:	71260					
Sample Size:	226	**Resp n:** 100		**Response:** 44.24 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.00	1.30	**1.60**	1.84	3.00
Pre-Service Evaluation Time:				**3.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		3.00	10.00	**15.00**	20.00	40.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
/1275	XXX	1.92

CPT Descriptor Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 23.0 %

TIME ESTIMATES (Median)	**CPT Code: 71260**	**Key Reference CPT Code: 71275**
Median Pre-Service Time	3.00	9.50
Median Intra-Service Time	15.00	30.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**23.00**	**49.50**
Other time if appropriate		0.00

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.14	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.64	3.50
Urgency of medical decision making	3.23	3.95

Technical Skill/Physical Effort (Mean)

Technical skill required	3.14	3.40
Physical effort required	2.32	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.34	3.45
Outcome depends on the skill and judgment of physician	3.75	3.95
Estimated risk of malpractice suit with poor outcome	3.73	3.75

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.59	2.79
Intra-Service intensity/complexity	3.66	4.03
Post-Service intensity/complexity	2.45	2.58

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

PLEASE SEE ATTACHED SHEET

SERVICES REPORTED WITH MULTIPLE CPT CODES

CPT Code:

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 87% No 13%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 8% I do not agree 92%
B. Patients requiring this service are now:
   more complex (more work) 85% less complex (less work) 1% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 7% from inpatient to outpatient 20% no change 73%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:72192 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.11**
RUC RVU: **1.09**

CPT Descriptor: Computed tomography, pelvis; without contrast material

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70 year old female with a long-standing history of degenerative arthritis has pelvic and hip pain following a fall. Plain radiographs of the pelvis demonstrate osteopoenia and complex fractures involving the sacrum and pubic rami. CT scan of the pelvis with axial, coronal and sagittal imaging is ordered.

(Note: Three-dimensional rendering, if ordered and performed, is coded separately. However, per CPT 2006, interpretation of two-dimensional thin section coronal and/or sagittal reformatted images is now included with 72192.)

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior imaging studies
- Determine the appropriate CT protocol for the examination and communicate that protocol to the CT technologists

Description of Intra-Service Work:
- Review and interpret scout radiographs
- Review initial and subsequent series of CT image data to assure adequacy of anatomic coverage and assess need for repeat sections
- Interpret the examination and compare to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.					
Specialty(s):	American College of Radiology					
CPT Code:	72192					
Sample Size:	226	**Resp n:** 100		**Response:** 44.24 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.70	1.11	**1.20**	1.50	2.50
Pre-Service Evaluation Time:				**3.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		4.00	6.00	**10.00**	15.00	30.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit. 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
72131	XXX	1.16

CPT Descriptor Computed tomography, lumbar spine; without contrast material

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 24.0 %

TIME ESTIMATES (Median)	**CPT Code: 72192**	**Key Reference CPT Code: 72131**
Median Pre-Service Time	3.00	0.00
Median Intra-Service Time	10.00	0.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**18.00**	**0.00**
Other time if appropriate		22.00

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.92	2.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.76
Urgency of medical decision making	3.67	2.48

Technical Skill/Physical Effort (Mean)

Technical skill required	3.08	3.14
Physical effort required	2.25	2.24

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.38	2.95
Outcome depends on the skill and judgment of physician	3.71	3.52
Estimated risk of malpractice suit with poor outcome	3.71	3.33

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.33	2.29
Intra-Service intensity/complexity	3.42	3.19
Post-Service intensity/complexity	2.38	2.33

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

PLEASE SEE ATTACHED SHEET

SERVICES REPORTED WITH MULTIPLE CPT CODES

CPT Code:

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 80% No 20%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 5% I do not agree 95%
B. Patients requiring this service are now:
   more complex (more work) 76% less complex (less work) 3% no change 21%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 16% no change 84%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:72193 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.20**
RUC RVU: **1.16**

CPT Descriptor: Computed tomography, pelvis; with contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old female presented with acute diverticulitis. CT scan at that time demonstrated inflammation of the sigmoid colon and stranding in the sigmoid mesentery, but no pericolonic abscess. After four days of intravenous antibiotics, the patient continues to have fever, pelvic pain, and leukocytosis. CT scan of the pelvis with oral, rectal and IV contrast is ordered.

(Note: Three-dimensional rendering, if ordered and performed, is coded separately. However, per CPT 2006, interpretation of two-dimensional thin section coronal and/or sagittal reformatted images is now included with 72193.)

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 5%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior imaging studies
- Determine the appropriate CT protocol for the examination and communicate that protocol to the CT technologists

Description of Intra-Service Work:
- Review and interpret scout radiographs
- Supervise administration of intravenous contrast
- Review initial and subsequent series of CT image data to assure adequacy of anatomic coverage and assess need for repeat sections
- Interpret the examination and compare to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.					
Specialty(s):	American College of Radiology					
CPT Code:	72193					
Sample Size:	269	**Resp n:** 100		**Response:** 37.17 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.70	1.20	**1.40**	1.70	2.50
Pre-Service Evaluation Time:				**3.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		3.00	7.00	**10.00**	15.00	35.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
74175	XXX	1.90

CPT Descriptor Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 21.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 72193**	**Key Reference CPT Code: 74175**
Median Pre-Service Time	3.00	10.00
Median Intra-Service Time	10.00	30.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**18.00**	**50.00**
Other time if appropriate		0.00

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.47
Urgency of medical decision making	3.55	3.74

Technical Skill/Physical Effort (Mean)

Technical skill required	3.15	3.53
Physical effort required	2.25	2.37

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.03	3.16
Outcome depends on the skill and judgment of physician	3.90	4.00
Estimated risk of malpractice suit with poor outcome	3.50	3.58

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.60	3.11
Intra-Service intensity/complexity	3.50	4.19
Post-Service intensity/complexity	2.30	2.61

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

PLEASE SEE ATTACHED SHEET

CPT Code:

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 82% No 18%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 10% I do not agree 90%
B. Patients requiring this service are now:
   more complex (more work) 82% less complex (less work) 2% no change 16%
C. The usual site-of-service has changed:
   from outpatient to inpatient 2% from inpatient to outpatient 20% no change 78%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:73100 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.16**
RUC RVU: **0.16**

CPT Descriptor: Radiologic examination, wrist; two views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56 year old woman with long-standing degenerative and CPPD arthritis has progressive wrist pain. AP and lateral views of the wrist are ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 1%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:
- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D., Jonathan Berlin, M. D. and Daniel Nagle, M. D.					
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons					
CPT Code:	73100					
Sample Size:	369	**Resp n:** 77		**Response:** 20.8 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.15	0.16	**0.16**	0 20	1.00	
Pre-Service Evaluation Time:			**1.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	1.00	2.00	**3.00**	3.00	10.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
73600	XXX	0.16

CPT Descriptor
Radiologic examination, ankle; two views

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36 **% of respondents:** 47.0 **%**

TIME ESTIMATES (Median)	**New/Revised CPT Code: 73100**	**Key Reference CPT Code: 73600**
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	**0.00**
Other time if appropriate		5 H

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.17	1.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.56	1.44
Urgency of medical decision making	1.72	1.79

Technical Skill/Physical Effort (Mean)

Technical skill required	1.83	1.88
Physical effort required	1.21	1.19

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.75	1.76
Outcome depends on the skill and judgment of physician	2.22	2.21
Estimated risk of malpractice suit with poor outcome	1.97	1.94

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.21	1.19
Intra-Service intensity/complexity	1.89	1.79
Post-Service intensity/complexity	1.21	1.16

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR and AAOS RUC Committees reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 6% No 94%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 40% I do not agree 60%
B. Patients requiring this service are now:
   more complex (more work) 20% less complex (less work) 0% no change 80%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 20% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:73110 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.17**
RUC RVU: **0.17**

CPT Descriptor: Radiologic examination, wrist; complete, minimum of three views

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old woman sustained an injury to the left wrist. Initial radiographs were negative. One week later the patient has persistent pain localized to the anatomic snuffbox. Four views of the wrist including a scaphoid view were ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:
- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D., Jonathan Berlin, M. D. and Daniel Nagle, M. D.					
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons					
CPT Code:	73110					
Sample Size:	369	**Resp n:** 77		**Response:** 20.86 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.16	0.17	**0.19**	0.23	1.00	
Pre-Service Evaluation Time:			**1.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	1.00	2.00	**3.00**	4.00	15.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
73610	XXX	0.17

CPT Descriptor Radiologic examination, ankle; complete, minimum of three views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 40 **% of respondents:** 52 %

TIME ESTIMATES (Median)	**New/Revised CPT Code: 73110**	**Key Reference CPT Code: 73610**
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	3.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	**3.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.20	1.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.65	1.43
Urgency of medical decision making	2.15	1.86

Technical Skill/Physical Effort (Mean)

Technical skill required	1.80	1.86
Physical effort required	1.22	1.21

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.26	1.86
Outcome depends on the skill and judgment of physician	2.48	2.19
Estimated risk of malpractice suit with poor outcome	2.70	2.14

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.26	1.23
Intra-Service intensity/complexity	2.08	1.92
Post-Service intensity/complexity	1.42	1.29

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR and AAOS RUC Committees reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 9% No 91%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 29% I do not agree 71%
B. Patients requiring this service are now:
   more complex (more work) 43% less complex (less work) 0% no change 57%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 29% no change 71%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:73120 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.16**
RUC RVU: **0.16**

CPT Descriptor: Radiologic examination, hand; two views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 55 year old woman with long-standing rheumatoid arthritis has developed worsening pain and deformity in her left hand. AP and lateral views of the hand were ordered for further evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:
- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Bibb Allen, Jr., M.D., Jonathan Berlin, M. D. and Daniel Nagle, M D.				
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons				
CPT Code:	73120				
Sample Size: 369	**Resp n:** 77	**Response:** 20.8 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	0.15	0.16	**0.17**	0.20	1.00
Pre-Service Evaluation Time:			**1.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	1.00	2 00	**3.00**	4.00	10.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
73620	XXX	0.16

CPT Descriptor Radiologic examination, foot; two views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 34 %

TIME ESTIMATES (Median)	**New/Revised CPT Code: 73120**	**Key Reference CPT Code: 73620**
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	
Other time if appropriate		5(H)

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.23	2.04
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.50	1.44
Urgency of medical decision making	1.77	1.72

Technical Skill/Physical Effort (Mean)

Technical skill required	1.81	1.84
Physical effort required	1.19	1.16

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.81	1.76
Outcome depends on the skill and judgment of physician	2.35	2.24
Estimated risk of malpractice suit with poor outcome	2.04	2.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.31	1.28
Intra-Service intensity/complexity	2.00	1.86
Post-Service intensity/complexity	1.35	1.36

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR and AAOS RUC Committees reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 6% No 94%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 40% I do not agree 60%
B. Patients requiring this service are now:
   more complex (more work) 20% less complex (less work) 0% no change 80%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 20% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:73130 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.17**
RUC RVU: **0.17**

CPT Descriptor: Radiologic examination, hand; minimum of three views

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 15 year old child slammed his hand against a wall at school. Pain is best localized to the ulnar aspect of the metacarpal region of the hand. AP, lateral and oblique views of the hand are ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:
- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate an report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M D., Jonathan Berlin, M. D. and Daniel Nagle, M. D.					
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons					
CPT Code:	73130					
Sample Size:	369	**Resp n:** 77		**Response:** 20.86 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.16	0.17	**0.18**	0.22	1.00	
Pre-Service Evaluation Time:			**1.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	1.00	2.00	**3.00**	4.00	15.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
73610	XXX	0.17

CPT Descriptor Radiologic examination, ankle; complete, minimum of three views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 40 %

TIME ESTIMATES (Median)	**New/Revised CPT Code: 73130**	**Key Reference CPT Code: 73610**
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	3.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	**3.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.03	1.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.58	1.53
Urgency of medical decision making	2.19	1.90

Technical Skill/Physical Effort (Mean)

Technical skill required	1.87	1.90
Physical effort required	1.25	1.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.10	2.00
Outcome depends on the skill and judgment of physician	2.26	2.20
Estimated risk of malpractice suit with poor outcome	2.32	2.17

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.28	1.29
Intra-Service intensity/complexity	2.10	1.95
Post-Service intensity/complexity	1.28	1.29

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR and AAOS RUC Committees reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 8% No 92%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 33% I do not agree 67%
B. Patients requiring this service are now:
   more complex (more work) 33% less complex (less work) 0% no change 67%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 17% no change 83%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:73140 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.13**
RUC RVU: **0.13**

CPT Descriptor: Radiologic examination, finger(s), minimum of two views

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26 year old male sustained a crush injury to his finger producing an open fracture of the middle phalanx. The presence of foreign material in the wound is questioned. AP, lateral and oblique views of the finger are ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 1%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:
- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D., Jonathan Berlin, M. D. and Daniel Nagle, M. D.					
Specialty(s):	American College of Radiology, American Academy of Orthopaedic Surgeons					
CPT Code:	73140					
Sample Size: 369	**Resp n:** 77	**Response:** 20.86 %				
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.10	0.15	**0.16**	0.17	1.00	
Pre-Service Evaluation Time:			**1.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	1.00	1.00	**2.00**	3.00	7.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
73600	XXX	0.16

CPT Descriptor Radiologic examination, ankle; two views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 36 %

TIME ESTIMATES (Median)	**New/Revised CPT Code: 73140**	**Key Reference CPT Code: 73600**
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	2.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**4.00**	**0.00**
Other time if appropriate		5 H

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.75	1.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.46	1.46
Urgency of medical decision making	2.36	1.96

Technical Skill/Physical Effort (Mean)

Technical skill required	1.71	1.69
Physical effort required	1.19	1.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	1.88
Outcome depends on the skill and judgment of physician	2.36	2.35
Estimated risk of malpractice suit with poor outcome	2.50	2.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.13	1.25
Intra-Service intensity/complexity	1.55	1.65
Post-Service intensity/complexity	1.36	1.78

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR and AAOS RUC Committees reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Iintensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 8% No 92%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 33% I do not agree 67%
B. Patients requiring this service are now:
   more complex (more work) 33% less complex (less work) no change 67%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 17% no change 83%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:74000 Global Period: XXX Specialty Society RVU: **0.18**

RUC RVU: **0.18**

CPT Descriptor: Radiologic examination, abdomen; single anteroposterior view

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old male had a 6 mm right ureteral stone in the middle third of the right ureter diagnosed by computed tomography. After three days the patient continues to experience abdominal pain and nausea. AP radiograph of the abdomen is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:

- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:

- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s).	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.					
Specialty(s):	American College of Radiology					
CPT Code:	74000					
Sample Size: 369	**Resp n:** 104	**Response:** 28.18 %				
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.12	0.20	**0.22**	0.25	2.00	
Pre-Service Evaluation Time:			**1.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	1.00	2.00	**3.00**	4.00	10.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
72100	XXX	0.22

CPT Descriptor Radiologic examination, spine, lumbosacral; two or three views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU
74400	XXX	0.49

CPT Descriptor 2 Urography (pyelography), intravenous, with or without KUB, with or without tomography

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39 **% of respondents:** 37.5 %

TIME ESTIMATES (Median)

	CPT Code: 74000	**Key Reference CPT Code: 72100**
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	
Other time if appropriate		6(H)

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.56	2.42
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.05
Urgency of medical decision making	2.82	2.16

Technical Skill/Physical Effort (Mean)

Technical skill required	2.13	2.16
Physical effort required	1.54	1.55

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.44	2.18
Outcome depends on the skill and judgment of physician	2.82	2.50
Estimated risk of malpractice suit with poor outcome	2 59	2.55

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.66	1.53
Intra-Service intensity/complexity	2.41	2.32
Post-Service intensity/complexity	1.78	1.66

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR RUC Committee reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 17% No 83%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 21% I do not agree 79%
B. Patients requiring this service are now:
   more complex (more work) 68% less complex (less work) no change 32%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 16% no change 84%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:				
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:74020 Global Period: XXX Specialty Society RVU: **0.27**

RUC RVU: **0.27**

CPT Descriptor: Radiologic examination, abdomen; complete, including decubitus and/or erect views

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old male who is unable to stand presents with progressive abdominal pain, nausea, and vomiting. Supine and left lateral decubitus views of the abdomen are ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:

- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:

- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.					
Specialty(s):	American College of Radiology					
CPT Code:	74000					
Sample Size: 369	**Resp n:** 104	**Response:** 28.18 %				
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.16	0.25	**0.28**	0.34	2.00	
Pre-Service Evaluation Time:			**1.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	1.00	3.00	**3.00**	5.00	10.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23), 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
72100	XXX	0.22

CPT Descriptor Radiologic examination, spine, lumbosacral; two or three views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU
74400	XXX	0.49

CPT Descriptor 2 Urography (pyelography), intravenous, with or without KUB, with or without tomography

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 43 **% of respondents:** 41.3 %

TIME ESTIMATES (Median)	**CPT Code: 74020**	**Key Reference CPT Code: 72100**
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	
Other time if appropriate		6.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.09	2.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.15
Urgency of medical decision making	3.23	2.26

Technical Skill/Physical Effort (Mean)

Technical skill required	2.53	2.18
Physical effort required	1.55	1.58

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.07	2.23
Outcome depends on the skill and judgment of physician	3.40	2.44
Estimated risk of malpractice suit with poor outcome	3.14	2.62

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.83	1.52
Intra-Service intensity/complexity	2.88	2.33
Post-Service intensity/complexity	2.02	1.68

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR RUC Committee reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 19% No 81%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 10% no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:74022 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.32**
RUC RVU: **0.32**

CPT Descriptor: Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40 year old female with a history of Crohn's disease and previous abdominal surgery presents with vomiting, abdominal distention and pain. A similar episode six months ago resolved without surgery. Acute abdomen series is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:
- Supervise technologist performing the examination
- Interpret the exam and compare the exam findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.				
Specialty(s):	American College of Radiology				
CPT Code:	74022				
Sample Size: 369	**Resp n:** 104	**Response:** 28.18 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	0.20	0.31	**0.35**	0.40	3.00
Pre-Service Evaluation Time:			**1.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	1.00	4.00	**3.00**	6.00	14.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit. 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
/2050	XXX	0.31

CPT Descriptor Radiologic examination, spine, cervical; minimum of four views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU
74400	XXX	0.49

CPT Descriptor 2 Urography (pyelography), intravenous, with or without KUB, with or without tomography

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36 **% of respondents:** 34.6 %

TIME ESTIMATES (Median)

	CPT Code: 74022	Key Reference CPT Code: 72050
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	3.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**5.00**	**0.00**
Other time if appropriate		8.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.37	2.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.47
Urgency of medical decision making	3.34	2.83

Technical Skill/Physical Effort (Mean)

Technical skill required	2.65	2.40
Physical effort required	1.60	1.63

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.83	2.57
Outcome depends on the skill and judgment of physician	3.31	2.97
Estimated risk of malpractice suit with poor outcome	3.32	3.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.61	1.52
Intra-Service intensity/complexity	3.03	2.77
Post-Service intensity/complexity	1.76	1.86

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR RUC Committee reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU

Pre-service Time: 0 minutes
Intra-service Time: 3 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 17% No 83%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) no change 25%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 20% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:74160 Global Period: XXX Specialty Society RVU: **1.35**
RUC RVU: **1.27**

CPT Descriptor: Computed tomography, abdomen; with contrast material(s)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old male with stage 4 pancreatic carcinoma and hepatic metastases has been treated with biliary stent placement and chemotherapy. After initial improvement, six months later the patient has nausea and recurrent jaundice. Contrast enhanced CT scan of the abdomen is ordered.

(Note: Three-dimensional rendering, if ordered and performed, is coded separately. However, per CPT 2006, interpretation of two-dimensional thin section coronal and/or sagittal reformatted images is now included with 74160.)

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 4%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior imaging studies
- Determine the appropriate CT protocol for the examination and communicate that protocol to the CT technologists

Description of Intra-Service Work:
- Review and interpret scout radiographs
- Supervise administration of intravenous contrast
- Review initial and subsequent series of CT image data to assure adequacy of anatomic coverage and assess need for repeat sections
- Interpret the examination and compare to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2006					
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.					
Specialty(s):	American College of Radiology					
CPT Code:	74160					
Sample Size:	226	**Resp n:** 100		**Response:** 44.24 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.90	1.35	**1.60**	1.80	3.00
Pre-Service Evaluation Time:				**3.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		3.00	10.00	**15.00**	20.00	40.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
74175	XXX	1.90

CPT Descriptor Computed tomographic angiography, abdomen, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 25.0 %

TIME ESTIMATES (Median)	**CPT Code: 74160**	**Key Reference CPT Code: 74175**
Median Pre-Service Time	3.00	10.00
Median Intra-Service Time	15.00	30.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**23.00**	**50.00**
Other time if appropriate		0.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.06	3.79
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.50
Urgency of medical decision making	3.71	3.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4.92	3.50
Physical effort required	2.38	2.50

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.38
Outcome depends on the skill and judgment of physician	4.04	4.05
Estimated risk of malpractice suit with poor outcome	3.71	3.68

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.75	3.04
Intra-Service intensity/complexity	3.77	4.06
Post-Service intensity/complexity	2.58	2.75

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

PLEASE SEE ATTACHED SHEET

SERVICES REPORTED WITH MULTIPLE CPT CODES

CPT Code:

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 85% No 15%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 8% I do not agree 92%
B. Patients requiring this service are now:
   more complex (more work) 85% less complex (less work) 1% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 4% from inpatient to outpatient 24% no change 72%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:76075 Global Period: XXX Specialty Society RVU: **0.30**

RUC RVU: **0.20**

CPT Descriptor: Dual energy x-ray absorptiometry (DXA), bone density study, one or more sites; axial skeleton (eg, hips, pelvis, spine)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66 year old woman had previous bone density demonstrating severe osteoporosis. The patient has been on hormone replacement therapy for one year and a follow-up DXA scan is ordered.

(Note: 76077 Vertebral fracture assessment when ordered and performed is coded separately)

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history
- Review any prior DXA studies

Description of Intra-Service Work:

Review scout images to assure scanning technique was satisfactory

- Interpret the DXA scan data and compare to established norms
- Compare the results of the DXA scan to previous studies
- Dictate report for the medical record

Description of Post-Service Work:

- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.					
Specialty(s):	American College of Radiology					
CPT Code:	76075					
Sample Size:	240	**Resp n:** 51		**Response:** 21.25 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.05	0.20	**0.30**	0.45	0.92
Pre-Service Evaluation Time:				**1.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		1.00	2.00	**4.00**	5.00	15.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
72050	XXX	0.31

CPT Descriptor Radiologic examination, spine, cervical; minimum of four views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU
74400	XXX	0.49

CPT Descriptor 2 Urography (pyelography), intravenous, with or without KUB, with or without tomography

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 23.5 %

TIME ESTIMATES (Median)

	CPT Code: 76075	Key Reference CPT Code: 72050
Median Pre-Service Time	1.00	0.00
Median Intra-Service Time	4.00	0.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**6.00**	**0.00**
Other time if appropriate		8.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.42	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.17	2.64
Urgency of medical decision making	1.25	2.73

Technical Skill/Physical Effort (Mean)

Technical skill required	1.67	2.09
Physical effort required	1.33	1.45

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.50	2.91
Outcome depends on the skill and judgment of physician	1.67	3.09
Estimated risk of malpractice suit with poor outcome	1.42	3.27

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.60	1.78
Intra-Service intensity/complexity	2.08	2.70
Post-Service intensity/complexity	1.82	2.10

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR RUC Committee reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. The RUC Committee considered the intensity of 76075 to be similar to the plain radiograph family of codes.
2. Time data is consistent with other XXX codes with similar RVU values. (For example, the work value and survey time for DXA is consistent with that obtained for code 74022 (Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest) in this Five Year Review.

3. Comparison to 73560 (Radiologic examination knee; one or two views) on the MPC A List with:
   Work RVU: 0.17 RVU
   Pre-service Time: 0 minutes
   Intra-service Time: 3 minutes
   Post Service Time: 0 minutes
4. Intensity/complexity measures are similar to the reference service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 33% No 67%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 12% I do not agree 88%
B. Patients requiring this service are now:
   more complex (more work) 59% less complex (less work) no change 41%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 18% no change 82%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:76700 Global Period: XXX Specialty Society RVU: **.81**

RUC RVU: **.81**

CPT Descriptor: Ultrasound, abdominal, B-scan and/or real time with image documentation; complete

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old male alcoholic has developed increasing abdominal distention, decreased urine output, and jaundice. A complete ultrasound examination of the abdomen is ordered for further evaluation.

(Note: Per CPT 2005, "A complete ultrasound examination of the abdomen (76700) consists of B mode scans of: liver, gallbladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava including any demonstrated abdominal abnormality.")

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:

- Supervise the sonographer performing the exam
- Interpret the ultrasound exam with evaluation of the following structures:
  - Liver, gallbladder and biliary tree
  - Spleen, pancreas and kidneys
  - Abdominal aorta and inferior vena cava
- Compare the exam and correlate the findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:

- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005		
Presenter(s):	Bibb Allen, Jr., M.D. and Jonathan Berlin, M. D.		
Specialty(s):	American College of Radiology		
CPT Code:	76700		
Sample Size:	279	**Resp n:** 101	**Response:** 36.20 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.69	0.84	**0.90**	1.00	2.40
Pre-Service Evaluation Time:			**3.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	3.00	6.00	**10.00**	15.00	30 00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**4.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
76770	XXX	0.74

CPT Descriptor Ultrasound, retroperitoneal (eg, renal, aorta, nodes), B-scan and/or real time with image documentation; complete

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
74400	XXX	0.49

CPT Descriptor 1 Urography (pyelography), intravenous, with or without KUB, with or without tomography

MPC CPT Code 2	Global	Work RVU
78707	XXX	0.96

CPT Descriptor 2 Kidney imaging with vascular flow and function; single study without pharmacological intervention

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 30.6 %

TIME ESTIMATES (Median)

	CPT Code: 76700	Key Reference CPT Code: 76770
Median Pre-Service Time	3.00	0.00
Median Intra-Service Time	10.00	0.00
Median Immediate Post-service Time	4.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**17.00**	**0.00**
Other time if appropriate		21.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.68	2.97
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.23	2.73
Urgency of medical decision making	3.00	2.73
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.58	3.20
Physical effort required	2.52	2.43
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.65	2.37
Outcome depends on the skill and judgment of physician	3.42	3.10
Estimated risk of malpractice suit with poor outcome	2.87	2.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.33	2.10
Intra-Service intensity/complexity	3.29	2.87
Post-Service intensity/complexity	2.19	2.03

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR RUC Committee reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the US family of codes.
2. Time data is consistent with other XXX codes with similar RVU values.
3. Although magnitude estimation supports an increase in value, the Committee decided that the time data and rank order considerations do not meet the compelling evidence standard for changing the value.

4. Although time data is similar to 76830, the RVU rank order is higher based on the number of organs examined and number of diagnoses to consider. This is supported by the differential in the surveyed RVU value between 76700 and 76830. Also time data for 76830 includes survey data from two cohorts (ACR and ACOG).
5. Comparison of intensity/complexity measures support preserving the relative rank order between 76700 and 76770.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 45% No 55%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 38% I do not agree 62%
B. Patients requiring this service are now:
   more complex (more work) 89% less complex (less work) no change 11%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 11% no change 89%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:76830 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **.69**
RUC RVU: **.69**

CPT Descriptor: Ultrasound, transvaginal

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old woman was diagnosed with a complex right ovarian cyst six weeks ago by trans-abdominal pelvic ultrasound. The lesion was presumed to represent a benign hemorrhagic cyst. After six weeks the patient has a persisting right adenexal mass on physical examination. A transvaginal examination ultrasound of the pelvis is ordered for further evaluation and characterization.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 1%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the reason for the exam and any pertinent clinical history
- Review any prior applicable imaging studies

Description of Intra-Service Work:
- Supervise the sonographer performing the exam
- Interpret the ultrasound exam with evaluation of the following structures:
  - Uterus including evaluation of the endoetrium
  - Ovaries
  - Cul de sac
- Compare the exam and correlate the findings to previous studies
- Dictate report for the medical record

Description of Post-Service Work:
- Review and sign final report
- Discuss findings with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Bibb Allen, Jr., M.D., Jonathan Berlin, M. D. and George Hill, M. D.					
Specialty(s):	American College of Radiology, American College of Obstetricians and Gynecologists					
CPT Code:	76830					
Sample Size:	279	**Resp n:** 143		**Response:** 51.25 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.50	0.69	**0.80**	0.99	1.80
Pre-Service Evaluation Time:				**3.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		1.00	7.00	**12.00**	15.00	45.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
76856	XXX	0.69

CPT Descriptor Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation; complete

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
74400	XXX	0.49

CPT Descriptor 1 Urography (pyelography), intravenous, with or without KUB, with or without tomography

MPC CPT Code 2	Global	Work RVU
78707	XXX	0.96

CPT Descriptor 2 Kidney imaging with vascular flow and function; single study without pharmacological intervention

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 63 **% of respondents:** 44.0 %

TIME ESTIMATES (Median)

	CPT Code: 76830	**Key Reference CPT Code: 76856**
Median Pre-Service Time	3.00	0.00
Median Intra-Service Time	12.00	0.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**20.00**	**0.00**
Other time if appropriate		20.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.30	3.21
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.05	3.02
Urgency of medical decision making	3.21	3.10
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.60	3.37
Physical effort required	2.62	2.52
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.40	2.29
Outcome depends on the skill and judgment of physician	3.57	3.44
Estimated risk of malpractice suit with poor outcome	3.29	3.15

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.34	2.26
Intra-Service intensity/complexity	3.16	2.97
Post-Service intensity/complexity	2.46	2.37

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The ACR and ACOG RUC Committees reviewed the survey data and concluded there is no compelling evidence to change the work RVU for this service. Rationale for the no change recommendation includes:

1. Rank order with the US family of codes.
   -Elements of 76830 are the same as 76856
2. Time data is consistent with other XXX codes with similar RVU values.

3. Although magnitude estimation supports an increase in value, the Committees decided that the time data and rank order considerations do not meet the compelling evidence standard for changing the value.
4. Comparison to CPT Code 76817 (Ultrasound, pregnant uterus, real time with image documentation, transvaginal) valued by the RUC in 2002:
   Work RVU: 0.75 RVU
   Pre-service Time: 5 minutes
   Intra-service Time: 10 minutes
   Post Service Time: 8 minutes

CPT Code 76817 includes all of the elements of 76830 as well as examination of the embryo/fetus. Therefore, the value of 76830 is appropriate at 0.69 RVU.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 43% No 57%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 33% I do not agree 67%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 8% no change 92%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77263 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **3.14**
RUC RVU: **3.14**

CPT Descriptor: Therapeutic radiology treatment planning; complex.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with T3N2 locally advanced nasopharyngeal carcinoma presents (following consultation 99xxx-x) for clinical treatment planning with curative intent.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: The physician integrates her analysis of the extent of disease and normal anatomy, and determines that three separate target volumes will be required; the primary tumor volume (CTV1), the regions of clinical lymphadenopathy in the neck (CTV2), and areas of potential sub-clinical disease in the supraclavicular fossae (CTV3). For each of these regions, the following must be considered, and a decision made:

1) Collateral factors. Numerous factors must be considered before making a decision on the treatment plan. These include the potential use of brachytherapy, radiation protectors (Amifostine), the presence of a PEG tube, the patients age and overall physical condition, the possible addition of chemotherapy (either neoadjuvantly, concomitantly, or maintenance), the presence of co-morbid conditions (diabetes, glaucoma, cataracts, dental condition, autoimmune conditions, prior chronic exposure to steroids, etc.), and a recognition of the inherent regional issues of radiation biology will all affect the selection of total dose, dose per fraction, beam geometry, planned treatment volume reductions, beam energy, and weighting.

2) Total dose, dose per fraction, and fractionation: The absorbed dose to each CTV will be different, and the radiation oncologist must decide, based on the patients overall condition, how much radiation can be delivered to each volume. Doses can vary by as much as 20-50% between various targets. After deciding on the total dose, the dose per fraction must be determined. This can also vary by 10-15% per day, depending on the volume to be radiated, the oncologists' assessment of the patients' tolerance, and the intrinsic biology of the disease. The fractionation is determined, either conventional (once per day, five days per week), hyperfractionated (twice per day), or a hybrid (conventional for the first component of the therapy and hyperfractionated for the boost).

3) Beam geometry and planned volume reductions: The radiation oncologist must create a beam geometry that can be physically delivered by the machine, is reproducible on a daily basis, and is within the tolerance of the immobilized patient. Parallel opposed, wedge pair, anterior-posterior, en face, or some combination thereof must be considered. The presence of adjacent, critical normal tissues (lens, retinas, optic nerves, optic chiasm, parotid glands, mandible, temporal lobes, pituitary gland, spinal cord, etc.) significantly affects the choice of the beam arrangement. Planned reductions in the treatment volumes (CTV's 1,2, and 3) also affect the geometry, and often eight to ten ports will be required to deliver the dose with the requisite safety.

4) Beam energy and weighting: The radiation oncologist must decide which beam energy is appropriate for each treatment set up. Low energy and high energy photons, as well as low, intermediate, and high energy electrons are available and must be considered. The depth of penetration with high energy photons must be balanced against the field

edge dose constriction, and lower energy x-rays need to be carefully considered with their higher internal scatter. Electrons may be valuable for selected volumes, but each electron energy has specific physics characteristics which must also be considered. Typically several beam energies are utilized and their relative proportions in each port must be determined.

As a result of the above process, the overall treatment plan emerges consisting of the types of radiation to be utilized, the areas to be treated, the techniques for treatment, the doses to be delivered, and the duration of therapy. This treatment plan would be described as follows:

1) CTV1:
a. 45 Gy in 25 fractions, 6 and 18 MV photons, combination beam weighted 3:2, parallel opposed right and left head and neck fields, angled 5 degrees posteriorly, 3D conformal planning, then
b. reduce and boost 14.4 Gy in 8 fractions, 6 and 18 MV photons, combination beam weighted 1:1, reduced parallel opposed right and left head and neck fields, at 90 degrees, then
c. 9 Gy in 5 fractions, 18 MV photons, reduced base of skull boost, parallel opposed weighted 1:1

2) CTV2:
a. 45 Gy in 25 fractions, 6 and 18 MV photons, combination beam weighted 3:2, parallel opposed right and left neck fields, angled 5 degrees posteriorly, 3D conformal planning, then
b. reduce and boost 14.4 Gy in 8 fractions, 6 and 18 MV photons, combination beam weighted 1:1, reduced parallel opposed right and left head and neck fields, then
c. 14.4 Gy in 8 fractions, 16 MV electrons, AP en face, off cord neck boost, calculation depth of 6 cm., ½ cm bolus skin every other treatment.

3) CTV 3:
a. 45 Gy in 25 fractions, 6 MV photons, AP en face low neck field, calculation depth 3 cm., mid-line cord block, matched to CTV 2 with match line change after 23.4 Gy in 13 fractions, then
b. 5.4 Gy in 3 fractions, AP en face right low neck boost, off cord, calculation depth 3 cm.

The patient is then ready for the next step in the process of care, the treatment simulation.

The radiation oncologist needs to assess the patient's nutritional status and the condition of the patient's teeth and gums. He or she then decides whether it is necessary to refer the patient to a gastroenterologist for possible feeding gastrostomy the technical alternative are evaluated by the physician and presented to the patient as need. Requirements for the planned daily treatment program are described and the simulation sessions are scheduled.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Paul Wallner, D.O., Najeeb Mohideen, M.D., and David Beyer, M.D.				
Specialty(s):	Radiation Oncology				
CPT Code:	77263				
Sample Size:	909	**Resp n:** 125	**Response:** 13.75 %		
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	3.30	**3.80**	4.50	11.00
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		

code77263

Pre-Service Scrub, Dress, Wait Time:				0.0		
Intra-Service Time:		30.00	75.00	**75.00**	120.00	480.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**0.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
77295	XXX	4.56

CPT Descriptor Therapeutic radiology simulation-aided field setting; three-dimensional.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 1 Radiation treatment management, five treatments.

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 55 **% of respondents:** 44.0 %

TIME ESTIMATES (Median)

	CPT Code: 77263	Key Reference CPT Code: 77295
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	75.00	98.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**75.00**	**98.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.24	4.16
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4 41	4.29
Urgency of medical decision making	3.89	3.91

Technical Skill/Physical Effort (Mean)

Technical skill required	4.35	4.36
Physical effort required	3.27	3.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.41	4.33
Outcome depends on the skill and judgment of physician	4.60	4.51
Estimated risk of malpractice suit with poor outcome	4.13	4.09

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.24	4.47
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We received over 100 completed surveys from our membership, of which 85% of the responses indicated that the work of performing the service has changed over the past 5 years. ASTRO's consensus panel reviewed the surveyed data and feels that the data supports a recommendation to maintain the current RUC RVU. The panel recommends that the median time is appropriate and therefore should be entered into the RUC database. Finally, the consensus panel reviewed the data and calculated the IWPUT. The results for an RVU recommendation of 3.14 (current) and a time recommendation of 90 minutes (median) were an IWPUT of 0.035. The current IWPUT is 0.043.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

   For an overview of the Radiation Oncology Process of Care, please see the attached flow chart.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 85% No 15%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 6% I do not agree 89%
B. Patients requiring this service are now:
   more complex (more work) 88% less complex (less work) 1% no change 8%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 3% no change 91%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 77263

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77280 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.70**
RUC RVU: **0.70**

CPT Descriptor: Therapeutic radiology simulation-aided field setting; simple.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 70 yr old male with metastatic colon cancer with bone metastases and low back pain has a bone scan which shows metastatic involvement in lumbar vertebrae 2 to 4 corresponding with the location of his pain. Following consultation (99xxx-x) and clinical treatment planning (77261-3) the patient presents for simulation.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 1%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: Patient is positioned prone on the simulation table and aligned using room lasers. The physician examines the patient clinically to determine the area of pain and reviews the bone scan. He then views the area of interest on fluoroscopy in the simulation room directing the radiation therapist to open the field borders to include the lower thoracic, lumbar and upper sacral vertebrae in the superoinferior directions. He then observes a fluoroscopic image to confirm that the patient is well aligned. If he cannot tolerate the prone position and maintain good alignment he has to be repositioned in the supine position and the process repeated. Once he is happy with the positioning the physician directs the therapist to open the collimator laterally to include the entire transverse processes of the vertebral bodies. He then carefully counts the vertebral bodies locating the 12 rib and the L5/ S1 junction to accurately identify the areas of disease. He includes lumbar vertebrae L1 - L5 in the superinferior margins of the field and he decides to limit the field width to cover the entire vertebral body with a margin. The field center is finalized and a single image is taken at 100 cm from the source to the skin. The hard copy is evaluated; the physician approves field borders and localization. The field center and alignment marks are placed by tattoo on the patient and the field borders are outlined by marking pen. The gantry is rotated 90 degrees and a lateral film is taken. The physician evaluates this to determine the depth of the lesion from the skin surface. Lateral skin marks are placed to help in aligning the patient on the treatment table. The patient is then taken off the table.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Paul Wallner, D.O., Najeeb Mohideen, M.D., and David Beyer, M.D.					
Specialty(s):	Radiation Oncology					
CPT Code:	77280					
Sample Size:	0	**Resp n:** 0		**Response:** 0.00 %		
Sample Type:						
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	

code 77280

Survey RVW:					
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:			**0.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
77285	XXX	1.05

CPT Descriptor Therapeutic radiology simulation-aided field setting; intermediate.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 1 Radiation treatment management, five treatments.

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 71 **% of respondents:** 62.8 %

TIME ESTIMATES (Median)	CPT Code: 77280	Key Reference CPT Code: 77285
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	0.00	46.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**0.00**	**46.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.69	3.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.89	3.25
Urgency of medical decision making	2.86	2.94

Technical Skill/Physical Effort (Mean)

Technical skill required	2.86	3.27
Physical effort required	2.31	2.66

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.89	3.19
Outcome depends on the skill and judgment of physician	2.95	3.24
Estimated risk of malpractice suit with poor outcome	2.66	2.99

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.61	3.20
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We received over 100 completed surveys from our membership, of which the majority felt that the work of performing the service has not changed over the past 5 years. ASTRO's consensus panel reviewed the surveyed data and feels that the data supports a recommendation to maintain the current RVUs. However, the panel recommends that the 25th percentile of time is more appropriate and would maintain rank order in this family of codes and therefore should be entered into the RUC database. Finally, the consensus panel reviewed the data and calculated the IWPUT. The results

for an RVU recommendation of 0.70 (current) and a time recommendation of 30 minutes (25th percentile) were an IWPUT of 0.023. The current IWPUT is 0.030.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Additional CPT codes that could be accompanied by the surveyed code include one of the treatment delivery codes (77401-77416). The global period for these codes are XXX. There are no work RUVs, or pre-, intra-, or post-time as these treatment delivery codes are TC-only codes.

   CPT Code 77427, with a global period of XXX, and work RVU of 3.31, and 20 minutes of pre-service, 40 minutes of intra-service, and 20 minutes of immediate post-service time, may also be billed along with the surveyed code.

   For an overview of the Radiation Oncology Process of Care, please see the attached flow chart.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 39% No 61%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 9% I do not agree 65%
B. Patients requiring this service are now:
   more complex (more work) 29% less complex (less work) 0% no change 44%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 4% no change 68%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 77280

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77290 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.56**
RUC RVU: **1.56**

CPT Descriptor: Therapeutic radiology simulation-aided field setting; complex.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 72-year-old male with localized prostate cancer (following consultation 99xxx-x, clinical treatment planning 77263) presents for simulation in anticipation of 3D treatment with curative intent.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 1%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: 72-year-old male with localized prostate cancer undergoes complex simulation for external beam radiotherapy to the pelvis. A customized immobilization device has been created for the patient. The physician discusses the procedure with the patient .The patient is positioned in this device and aligned using four directional alignment lasers. The alignment is checked by the physician under fluoroscopy and adjustments are made till it is perfectly aligned. Using sterile techniques the bladder is catheterized by the physician and dilute contrast is instilled into the bladder. The catheter is then removed and a urethrogram is performed .The penis is clamped so that the dye is retained within the urethra. Fluoroscopy is performed to ensure the visualization of the urethra and bladder is acceptable and the apex of the urethrogram can be identified on the AP view. Barium is then introduced into the rectum through a rectal catheter. The physician again checks the localization and determination of image adequacy to ensure anatomical localization under fluoroscopic control. After approval of this AP localization x-ray by the physician the therapist is instructed to rotate the simulator gantry to a 90-degree right lateral position. This image is viewed under fluoroscopic control to see that the rectal outline, bladder and the beak of the urethrogram (which reflects the inferior aspect of the urogenital diaphragm approximating the prostate apex) are well visualized. The isocenter is then determined by the physician after reviewing both lateral and anterior images. Once the isocenter is established the field are opened to include the whole pelvis both on the AP and lateral views. Four hard copy x-rays hard copies (AP, PA, R lat and L Lat) are taken. These images are reviewed by the physician and approved. The patient is marked at the isocenter both AP and lateral. The penile clamp is removed which allows the dye to drain out and the rectal catheter is also removed. The patient is examined to make sure he has no associated effects from these invasive procedures or the contrast dye. The patient is taken off the table.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005		
Presenter(s):	Paul Wallner, D.O., Najeeb Mohideen, M.D., and David Beyer, M.D.		
pecialty(s):	Radiation Oncology		
CPT Code:	77290		
Sample Size:	897	**Resp n:** 107	**Response:** 11.92 %

Sample Type: Random						
		Low	25th pctl	Median*	75th pctl	High
Survey RVW:		1.15	1.70	**2.05**	3.19	10.00
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		25.00	70.00	**70.00**	110.00	450.00
Post-Service	Total Min**	CPT code / # of visits				
Immed. Post-time:	0.00					
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
77295	XXX	4.56

CPT Descriptor Therapeutic radiology simulation-aided field setting; three-dimensional.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 1 Radiation treatment management, five treatments.

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 37 **% of respondents:** 34.5 %

TIME ESTIMATES (Median)	**CPT Code: 77290**	**Key Reference CPT Code: 77295**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	70.00	98.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**70.00**	**98.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.93	4.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	4.05
Urgency of medical decision making	3.50	3.47

Technical Skill/Physical Effort (Mean)

Technical skill required	4.04	4.43
Physical effort required	3.25	3.65

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.08	4.41
Outcome depends on the skill and judgment of physician	4.22	4.54
Estimated risk of malpractice suit with poor outcome	3.99	4.22

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.91	4.44
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We received over 100 completed surveys from our membership, of which many of the responders felt that the work of performing the service has changed over the past 5 years (66%). However, ASTRO's consensus panel reviewed the surveyed data and feels that the data supports a recommendation to maintain the current RVUs. The panel recommends that the 25th percentile of time is more appropriate and would maintain rank order in this family of codes and therefore should be entered into the RUC database. Finally, the consensus panel reviewed the data and calculated the IWPUT.

The results for an RVU recommendation of 1.56 (current) and a time recommendation of 70 minutes (25th percentile) were an IWPUT of 0.022, which the consensus panel feels is more accurate then the current IWPUT is 0.0175.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Additional CPT codes that could be accompanied by the surveyed code include one of the treatment delivery codes (77401-77416). The global period for these codes are XXX. There are no work RUVs, or pre-, intra-, or post-time as these treatment delivery codes are TC-only codes.

   CPT Code 77427, with a global period of XXX, and work RVU of 3.31, and 20 minutes of pre-service, 40 minutes of intra-service, and 20 minutes of immediate post-service time, may also be billed along with the surveyed code.

   For an overview of the Radiation Oncology Process of Care, please see the attached flow chart.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 66% No 34%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 12% I do not agree 73%
B. Patients requiring this service are now:
   more complex (more work) 69% less complex (less work) 2% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 5% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 77290

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77300 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.62**
RUC RVU: **0.62**

CPT Descriptor: Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Following simulation (77280-77290) and isodose planning (77305-77315 or 77295) for a T3 N1 squamous cell carcinoma of the lung, a right anterior oblique/left posterior oblique field is being utilized as a component of a multifield beam arrangement to a mediastinal PTV and requires central axis depth dose calculation.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: The effort of the basic dosimetry calculation starts when the physician verifies the beam energy of the two fields, the field sizes, collimator sizes and the equivalent square. All four parameters are essential to the accuracy of the calculation. The patient thickness and calculation depth are reviewed. The calculation methodology (SSD or SAD) is verified. The appropriate absorption ratio (% depth dose, tissue air ratio, or tissue maximum ratio) is checked. The use of heterogeneity correction is verified. Beam weighting and reciprocal geometry are assessed. Correction factors, including the potential use of a wedge, compensator, bolus, and immobilization device are considered. After the accuracy of these parameters is assured, the calculated dose to the reference depth is calculated.

This dose absorption at depth is then converted into monitor units using the conversion factors for the standard output for the standard field at the reference depth. The physician then approves these monitor units for this specific field by signing and dating the plan.

Sample Calculation:

DESCRIPTION	BEAM NUMBER 1	BEAM NUMBER 2
	RAO lung	LPO lung
Machine ID	Varian EX SN 002174	Varian EX SN 02174
Collimator	Symmetric	Symmetric
BEAM ENERGY	6 x	6 x
SETUP DISTANCE	SAD 100	SAD 100
SSD	89.5	87.2
FIELD DEFINED AT	Isocenter	Isocenter
Width (cm, L,R)	4.9,6.0	4.9,6.0
Length (cm, S,I)	6.4,7.0	6.4,7.0
COLLIMATOR EQUIVALENT SQUARE	12.4	12.4
BLOCK EQUIVALENT SQUARE	11.1	11.1
GANTRY/COLLIMATOR ANGLE	160/90	20/90
Couch (degrees)	180	180

ISOCENTER BEAM ENTRY OFFSETS	Isocentric	Isocentric
X offset	0.0	0.0
Y offset	0.0	0.0
Z offset	0.0	0.0
TREATMENT AIDS		
Wedge ID/orientation	Dynamic/Toe in	Dynamic/Toe in
Wedge factor	0.700/normalized	0.700/normalized
MULITLEAF COLLIMATOR	N/A	N/A
CALCULATION ALGORITHM	Convolution	Convolution
BEAM WEIGHTING/No. FRACTIONS	2250/25	2250/25
Depth defined, cm	10.5	12.8
PDD/TAR/TMR	TMR	TMR
At depth	0.883	0.869
DOSE OUTPUT	101.9	103.6
Reference Depth	10.0	10.0
TRAY FACTOR	1.000	1.000
Dose output at reference depth	0.858 cGy/MU	0.858 cGy/MU
Monitor Units	118.7 MU	120.7 MU
INTEGER MONITOR UNITS	119	121

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s)	Paul Wallner, D.O. Najeeb Mohideen, M.D., and David Beyer, M.D.					
Specialty(s):	Radiation Oncology					
CPT Code:	77300					
Sample Size:	908	**Resp n:** 114		**Response:** 12.55 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.40	0.65	**0.70**	0.84	6.80
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		4.00	15.00	**15.00**	30.00	130.00

ost-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**

Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
77305	XXX	0.70

CPT Descriptor Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest).

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 1 Radiation treatment management, five treatments.

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 76 **% of respondents:** 66.6 %

TIME ESTIMATES (Median)

	CPT Code: 77300	Key Reference CPT Code: 77305
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	15.00	31.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**15.00**	**31.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.47	2.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.62	2.68
Urgency of medical decision making	2.74	2 71

Technical Skill/Physical Effort (Mean)

Technical skill required	3.16	3.25
Physical effort required	2.16	2.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.38	3.40
Outcome depends on the skill and judgment of physician	3.18	3.30
Estimated risk of malpractice suit with poor outcome	3.42	3.53

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.82	2.89
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We received over 100 completed surveys from our membership, of which the majority felt that the work of performing the service has not changed over the past 5 years. ASTRO's consensus panel reviewed the surveyed data and feels that the data supports a recommendation to maintain the current RVUs. The panel recommends that the median of time is appropriate, and therefore should be entered into the RUC database. Finally, the consensus panel reviewed the data and calculated the IWPUT. The results for an RVU recommendation of 0.62 (current) and a time recommendation of 20 minutes (median) were an IWPUT of 0.031. The current IWPUT is 0.041.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

   For an overview of the Radiation Oncology Process of Care, please see the attached flow chart.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 32% No 69%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 8% I do not agree 69%
B. Patients requiring this service are now:
   more complex (more work) 36% less complex (less work) 1% no change 40%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 3% no change 74%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 77300

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference etween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77315 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.56**
RUC RVU: **1.56**

CPT Descriptor: Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Following simulation (77280-77290)(note: cannot be part of a 3-dimension plan 77295, and cannot be part of an IMRT plan 77301), Complex blocked AP:PA fields are required to treat the supraclavicular nodes, mediastinum and involved areas of the right lung. Computer generated Isoplans are developed.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Description of Intra-Service Work: The physician assesses the anatomical relationships depicted in the planning computer and compares it to the diagnostic imagery to verify their accuracy. This includes the lung volumes, spinal cord, esophagus, heart, and the clinical target volumes (primary tumor, lymph node metastases, and potential sites of sub-clinical disease). The location of the isocenter, field size and beam geometry is assessed. The placement of beam-modifying devices is checked. For the wedge, the physical size and orientation are carefully verified. The beams themselves are then reviewed, including energy, SSD, collimated field size, gantry angle, couch rotation, calculation algorithm (i.e. Clarkson, Convolutional, pencil beam, Superposition, etc.), dose absorption ratios (TAR, TPR, or PDD), and heterogeneity factors to verify accuracy of the target volumes. The plan is then modeled by the dosimetrist and the initial isodose distribution is created and submitted to the physician for review.

The dose exposure to the planning target volumes, the dose gradients in critical adjacent normal tissues, and the maximum dose within the calculation matrix is considered. The physician decides how the dose should be specified, by selecting a specific intensity which offers the best trade-off between the dose necessary to control the tumor and the tolerance of the normal tissue. Several plans are required and the process is repeated until a satisfactory dose distribution is obtained. This change may be as minor as a change in the beam weights or a total change in the beam geometry. After an acceptable plan has been calculated, the physician then selects the "isodose line" for the plan which will be used in subsequent calculations. In this case the physician might select the "92% line" as the reference. The physician signs and dates the plan.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Paul Wallner, D.O., Najeeb Mohideen, M.D., and David Beyer, M.D.					
Specialty(s):	Radiation Oncology					
CPT Code:	77315					
Sample Size:	910	**Resp n:** 108		**Response:** 11.86 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.50	1.60	**1.80**	2.10	45.00	
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	10.00	45.00	**45.00**	70.00	270.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
77305	XXX	0.70

CPT Descriptor Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest).

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 1 Radiation treatment management, five treatments.

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 42 **% of respondents:** 38.8 %

TIME ESTIMATES (Median)	**CPT Code: 77315**	**Key Reference CPT Code: 77305**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	45.00	31.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**45.00**	**31.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.69	2.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	2.83
Urgency of medical decision making	3.43	2.81

Technical Skill/Physical Effort (Mean)

Technical skill required	3.95	2.86
Physical effort required	2.98	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.07	3.26
Outcome depends on the skill and judgment of physician	4.19	3.19
Estimated risk of malpractice suit with poor outcome	3.96	3.14

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.91	2.76
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We received over 100 completed surveys from our membership, of which many of the responders felt that the work of performing the service has changed over the past 5 years (54%). However, ASTRO's consensus panel reviewed the surveyed data and feels that the data supports a recommendation to maintain the current RVUs. The panel recommends that the median time is more appropriate and therefore should be entered into the RUC database. Finally, the consensus panel reviewed the data and calculated the IWPUT. The results for an RVU recommendation of 1.56 (current) and a time recommendation of 55 minutes (median) were an IWPUT of 0.028. The current IWPUT is 0.033.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

   For an overview of the Radiation Oncology Process of Care, please see the attached flow chart.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 54% No 46%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 11% I do not agree 76%
B. Patients requiring this service are now:
   more complex (more work) 57% less complex (less work) 0% no change 31%
C. The usual site-of-service has changed:
   from outpatient to inpatient 1% from inpatient to outpatient 6% no change 81%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 77315

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77331 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.87**
RUC RVU: **0.87**

CPT Descriptor: Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Following clinical planning (77261-77263), simulation (77280-77290), treatment isodose plan a patient begins treatment (77401-77416) with a 4 field plan to a maxillary sinus PTV and presents for physical dose measurement to normal tissue.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 1%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: The dosimeter is placed on the region of interest, with careful attention being paid to the geometry of the diode relative to the isocenter of the field. The SSD is measured. A digital image of the setup is taken. The diode is registered at zero before the exposure. After the system is checked the patient is given the radiation treatment. The monitor units delivered are checked with the reference treatment. The measured dose is recorded for calculation of the absorbed dose.

For the calculation, the measured SSD for the treatment field, the distance factor (DF), output adjustment factor (OAF), and scatter factor are calculated and checked. The calculated dose: measured dose ratio is calculated. This ratio is interpreted by the physician, and if it is out of tolerance the calculated dose is revisited and modified. The physician signs and dates the calculation.

SAMPLE CALCULATION:

Measured dose = IVD reading x DF x SF x OAF

Distance Factor (DF) = $[(\text{IVD SSD} - 0.4\text{ cm})^2] / [(\text{Calc SSD} + \text{D max})^2]$

Scatter Factor and Output Adjustment Factor from tables based on beam energy, SSD, wedge size and offset distance.

CALCULATED DOSE FROM DOSIMETRY CALCULATION

MEASUREMENT	READING
IVD SSD	89.2
IVD Reading	83
Off axis distance	0
Beam	6x
Calc SSD	89.6
DF	0.909
SF	0.962
OAF	1.017
Wedge	1.050
Measured Dose	72.6
Calculated Dose	72.9

MEASURED/CALCULATED 0.996

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s)	Paul Wallner, D.O., Najeeb Mohideen, M.D., and David Beyer, M.D.					
Specialty(s):	Radiation Oncology					
CPT Code:	77331					
Sample Size:	909	**Resp n:** 104		**Response:** 11.44 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.40	0.70	**0.90**	1.00	3.00	
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	4.00	20.00	**30.00**	40.00	165.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
/7305	XXX	0.70

CPT Descriptor Teletherapy, isodose plan (whether hand or computer calculated); simple (one or two parallel opposed unmodified ports directed to a single area of interest).

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 1 Radiation treatment management, five treatments.

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 39 **% of respondents:** 37.5 %

TIME ESTIMATES (Median)	CPT Code: 77331	Key Reference CPT Code: 77305
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	30.00	31.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**30.00**	**31.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.72	2.76
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.84	2.89
Urgency of medical decision making	2.86	2.84

Technical Skill/Physical Effort (Mean)

Technical skill required	3.07	3.08
Physical effort required	2.54	2.74

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.08	3.05
Outcome depends on the skill and judgment of physician	3.04	3.03
Estimated risk of malpractice suit with poor outcome	3.23	3.26

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	2.99	3.00
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

/e received over 100 completed surveys from our membership, of which the majority felt that the work of performing the service has not changed over the past 5 years. ASTRO's consensus panel reviewed the surveyed data and feels that the data supports a recommendation to maintain the existing RVUs. The panel recommends that the median time is appropriate and therefore should be entered into the RUC database. This is a unique procedure in radiation oncology and does not belong to a "family". Although the 77305 was selected for the reference service code, it was not selected

by an overwhelming majority (37.5%). There is no "true" reference service code for this surveyed procedure. Finally, the consensus panel reviewed the data and calculated the IWPUT. The results for an RVU recommendation of 0.87 (existing RVUs) and a time recommendation of 30 minutes (median) were an IWPUT of 0.029. The current IWPUT is 0.025.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Additional CPT codes that could be accompanied by the surveyed code include one of the treatment delivery codes (77401-77416). The global period for these codes are XXX. There are no work RUVs, or pre-, intra-, or post-time as these treatment delivery codes are TC-only codes.

   CPT Code 77427, with a global period of XXX, and work RVU of 3.31, and 20 minutes of pre-service, 40 minutes of intra-service, and 20 minutes of immediate post-service time, may also be billed along with the surveyed code.

   For more of an overview of the Radiation Oncology Process of Care, please see the attached flow chart.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 26% No 75%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 11% I do not agree 57%
B. Patients requiring this service are now:
   more complex (more work) 27% less complex (less work) 1% no change 40%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 4% no change 63%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 77331

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77334 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.24**
RUC RVU: **1.24**

CPT Descriptor: Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Following clinical planning (77261-77263), simulation (77280-77290), treatment isodose plan (77305-77315) or a 3-D plan (77295) or an IMRT plan (77301), a 61 yr old woman with stage IIIb (T2N3M0) non-small cell lung cancer will be treated with concurrent chemotherapy and multiple field radiotherapy and presents for design and construction of the custom blocks. The AP custom block lung/mediastinal field is designed and constructed.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: The work of the physician designing a custom treatment device starts after the dosimetrist prepares a DRR of the chest with the isocenter, CTV(s), and preliminary field size have been uploaded from the simulator and fused with the diagnostic imagery from the PACS. The physician reviews the anatomical relationships and physically designs and outlines the collimated field in the computer. This generates the pattern which approximates the physician's intent and a preliminary multi-leaf (MLC) pattern is created. Each MLC leaf is 5 mm in size (a 10 x 10 cm field would have 40 MLC leaves), and they are adjusted with the edge of the leaf "inbound", "midbound", or "outbound", depending on the proximity to the CTV or an adjacent critical structure, for example the spinal cord or esophagus. The computer then generates the reciprocal field, reconstructed as a DRR with the identical MLC shape projected on the target volumes. Adjustments may need to be made on this opposite field because of projection differences between the AP and the PA fields. Any changes made are then rechecked on the AP field to ensure that coverage remains adequate and normal tissues are protected.

After this is accomplished the physician then reviews the reconstructed CT images from the PACS inventory, overlaid with the MLC shape from the treatment planning system. Typical slice thickness for a CT scan of the lung used for treatment planning is 3-5 mm; a field which is 12 cm long requires the review of at least 24 images in the axial plane. Review is also performed in the reconstructed coronal planes to ensure that coverage is complete.

The approved MLC pattern is downloaded into the MLC controller on the accelerator and an electronic image taken. The physician reviews this image and makes any necessary minor adjustments. The physician electronically approves the device and authorizes its release to the treatment machine. It is used throughout the specified course of therapy.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Paul Wallner, D.O., Najeeb Mohideen, M.D., and David Beyer, M.D.				
Specialty(s):	Radiation Oncology				
CPT Code:	77334				
Sample Size: 898	**Resp n:** 104	**Response:** 11.58 %			
Sample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	0.52	1.23	**1.40**	1.50	8.00
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	12.00	35.00	**35.00**	71.25	210.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
77332	XXX	0.54

CPT Descriptor Treatment devices, design and construction; simple (simple block, simple bolus).

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 1 Radiation treatment management, five treatments.

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 59 **% of respondents:** 56.7 %

TIME ESTIMATES (Median)

	CPT Code: 77334	Key Reference CPT Code: 77332
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	35.00	28.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**35.00**	**28.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.53	2.14
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	2.37
Urgency of medical decision making	3.25	2.24

Technical Skill/Physical Effort (Mean)

Technical skill required	3.84	2.39
Physical effort required	2.97	2.07

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.94	2.64
Outcome depends on the skill and judgment of physician	4.00	2.68
Estimated risk of malpractice suit with poor outcome	3.70	2.59

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	3.67	2.44
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We received over 100 completed surveys from our membership, of which many of the responders felt that the work of performing the service has changed over the past 5 years (66%). However, ASTRO's consensus panel reviewed the surveyed data and feels that the data supports a recommendation to maintain the current RVUs. The panel recommends that the 25th percentile of time is more appropriate and therefore should be entered into the RUC database. Finally, the consensus panel reviewed the data and calculated the IWPUT. The results for an RVU recommendation of 1.24

(current) and a time recommendation of 35 minutes (25th percentile) were an IWPUT of 0.035. The current IWPUT is 0.032.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Additional CPT codes that could be accompanied by the surveyed code include 77290* with a global period of XXX, and work RVU of 1.56, and total time Harvard is 89 minutes (intra), or 77295 with an global period of XXX, and work RVU of 4.56, and total Harvard time is 98 minutes (intra).
   *Currently Surveyed Code

   For an overview of the Radiation Oncology Process of Care, please see the attached flow chart.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 66% No 32%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 15% I do not agree 68%
B. Patients requiring this service are now:
   more complex (more work) 60% less complex (less work) 6% no change 20%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 6% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 77334

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77470 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **2.09**
RUC RVU: **2.09**

CPT Descriptor: Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation).

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Following consultation (99240-99245), clinical treatment planning (77261-77263) it is determined that a 45-year-old female with clinical stage IIA squamous carcinoma of the cervix will be treated with a combination of external beam radiation therapy (EBRT) and brachytherapy.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 13%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: The physician must first evaluate each treatment plan individually, recognizing that the biologic differences between daily external beam treatment and brachytherapy are substantial. When delivered together, the risks of toxicity are much greater then either modality alone. The patient's pelvis is to be treated with 20 ractions to 39.6 Gy to the primary tumor and lymph nodes with external beam radiation with an additional boost to the pelvic sidewall. Brachytherapy will be sandwiched between the initial external beam therapy and the boost. Depending on the patient's age and general physical condition, the type of brachytherapy needs to be determined. It may be delivered using a tandem and ovoid with low dose rate (LDR) brachytherapy, thus precipitating a hospital admission for two fractions. Alternatively, the brachytherapy is to be delivered as an outpatient in 5 or 6 fractions using high-dose rate (HDR) brachytherapy.

The combined dose is evaluated by recreating the external beam plan on to the brachytherapy plan. This includes calculation of the bioeffective dose (BED) to the tumor (points A, point B) for the different forms of radiation, and calculation of time and dose rates factors, providing measures to limit the bladder and rectum within specified dose constraints. Consideration of the different BED's for tumor and normal tissue are used to guide the amount and ratio of dose administered by both external and brachytherapy modalities. Additional external beam radiation fields to the lateral pelvic structures are required to boost disease. The physician has to to verify that the high dose volume of brachytherapy is under the block and additional evaluation, measurements and calculations to ensure the accuracy of the block match during the pelvic side wall boost process are done. This code is not to be utilized for the work of each treatment modality, but represents the added work in evaluation, planning and direct patient care, and is only billed once for the entire course of treatment.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005

Presenter(s):	Paul Wallner, D.O., Najeeb Mohideen, M D., and David Beyer, M.D.
Specialty(s):	Radiation Oncology
CPT Code:	77470

Sample Size: 0	**Resp n:** 0	**Response:** 0.00 %

Sample Type:

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:					
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:			**0.00**		

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
77427	XXX	3.31

CPT Descriptor Radiation treatment management, five treatments.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 1 Radiation treatment management, five treatments.

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 42 **% of respondents:** 39.6 %

TIME ESTIMATES (Median)

	CPT Code: 77470	Key Reference CPT Code: 77427
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	0.00	40.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**0.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.22	3.95
Urgency of medical decision making	3.88	3.90

Technical Skill/Physical Effort (Mean)

Technical skill required	4.34	3.95
Physical effort required	3.75	3.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.45	4.02
Outcome depends on the skill and judgment of physician	4.43	4.29
Estimated risk of malpractice suit with poor outcome	1.23	3.98

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.28	4.05
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

We received over 100 completed surveys from our membership, of which many of the responders felt that the work of performing the service has changed over the past 5 years (58%). However, ASTRO's consensus panel reviewed the surveyed data and feels that the data supports a recommendation to maintain the current RVUs. The panel recommends that the median time is more appropriate and therefore should be entered into the RUC database. Finally, the consensus panel reviewed the data and calculated the IWPUT. The results for an RVU recommendation of 2.09 (current) and a time recommendation of 90 minutes (median) were an IWPUT of 0.023. The current IWPUT is 0.038.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

   For an overview of the Radiation Oncology Process of Care, please see the attached flow chart.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 58% No 42%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 5% I do not agree 84%
B. Patients requiring this service are now:
   more complex (more work) 69% less complex (less work) 0% no change 20%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 16% no change 72%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 77470

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78306 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.86**
RUC RVU: **0.86**

CPT Descriptor: Bone and/or joint imaging, whole body

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 57-year-old man with a history of prostate carcinoma presents with a PSA level of 11.7 and pain in his right pelvic region. A radionuclide bone scan is requested to assess the cause of the pain in his pelvis and the extent of any metastatic bone disease.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 99%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, x-rays and any prior bone imaging data. An interim medical history, including medications and concurrent medical problems, is obtained. The decision is made as to the appropriateness of a bone scan for this patient. The physician may consult with the ordering physician to clarify the indications. The physician orders the appropriate radiopharmaceutical and dose and assures appropriate records are maintained per NRC/state regulations.

Description of Intra-Service Work: The prescribed dose is administered intravenously and the patient is instructed to drink fluids for the several hours between injection and imaging. A whole body imaging study, including anterior and posterior images and lateral images of the skull, is obtained by the NM technologist. The initial imaging data is reviewed by the interpreting physician and compared to any previous radionuclide and other imaging bone data. Additional bone images are requested based on the initial imaging findings. These additional images are reviewed by the interpreting physician. A formal consultative report is dictated for the medical record.

Description of Post-Service Work: The interpreting physician reviews his consultative report and signs it. The imaging results may be discussed with the referring physician and may be discussed with the patient. Additional plain radiographs may be ordered after discussion with the referring physician. Regulatory (NRC/state) review and oversight is provided by the physician throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005		
Presenter(s):	Gary Dillehay, MD, Kenneth McKusick, MD, Bibb Allen, MD		
Specialty(s):	Society of Nuclear Medicine and American College or Radiology		
CPT Code:	78306		
Sample Size:	488	**Resp n:** 86	**Response:** 17.62 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.50	0.86	**0.90**	1.00	10.50
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		

CPT Code:

Intra-Service Time:		5.00	5.00	**8.00**	15.00	40.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
78802	XXX	0.86

CPT Descriptor Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
78707	XXX	0.96

CPT Descriptor 1 Kidney imaging with vascular flow and function; single study without pharmacological intervention

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 43 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)

	CPT Code: 78306	**Key Reference CPT Code: 78802**
Median Pre-Service Time	5.00	12.50
Median Intra-Service Time	8.00	17.50
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**18.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.36	3.12
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.12
Urgency of medical decision making	2.58	3.05
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.03	3.05
Physical effort required	2.10	2.12
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.53	2.67
Outcome depends on the skill and judgment of physician	3.56	3.51
Estimated risk of malpractice suit with poor outcome	3.08	3.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.40	2.58
Intra-Service intensity/complexity	3.12	3.16
Post-Service intensity/complexity	2.46	2.56

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society of Nuclear Medicine and the American College of Radiology convened a consensus panel to review the random sample AMA RUC survey summary data from the two professional societies. After lengthy discussion it was the consensus of the group that there was no compelling evidence at this time to recommend a change in the RVW value for CPT 78306.

Comparison to CPT 78707, Kidney imaging with vascular flow and function; single study without pharmacological intervention: MPC A List

CPT Code:

Work RVU: 0.96 RVU
Pre-service Time: 0 minutes
Intra-service Time: 22 minutes
Post Service Time: 0 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 25% No 75%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 5% I do not agree 95%
B. Patients requiring this service are now:
   more complex (more work) 67% less complex (less work) 0% no change 33%
C. The usual site-of-service has changed:
   from outpatient to inpatient 10% from inpatient to outpatient 20% no change 70%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:		18.0	
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:78315 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.02**
RUC RVU: **1.02**

CPT Descriptor: Bone and/or joint imaging; three phase study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old man with a history of diabetes presents with a painful ulcer on his left great toe. A three-phase radionuclide bone scan is requested to evaluate for osteomyelitis.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 99%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records, x-rays and any prior bone imaging data. An interim medical history, including medications and concurrent medical problems, is obtained. The decision is made as to the appropriateness of a 3 phase bone scan for this patient. The physician may consult with the ordering physician to clarify the indications. The physician orders the appropriate radiopharmaceutical and dose and assures appropriate records are maintained per NRC/state regulations.

Description of Intra-Service Work: The physician supervises the positioning of the patient for the flow study. A dynamic flow study is obtained as the prescribed dose is administered as a bolus intravenously through an antecubital vein. Static spot images of the plantar aspects of both feet are immediately obtained. These images are then repeated 10 minutes later. The patient is told to drink fluids for the several hours between injection and imaging. Plantar, anterior and lateral images of both feet are also obtained. A whole body imaging study, including anterior and posterior images and lateral images of the skull, is then obtained by the NM technologist. The imaging data is reviewed by the interpreting physician and compared to any previous radionuclide and other imaging bone data. Additional bone images are requested based on the initial imaging findings. These additional images are reviewed by the interpreting physician. A formal consultative report is dictated for the medical record.

Description of Post-Service Work: The interpreting physician reviews his consultative report and signs it. The imaging results are discussed with the referring physician and may be discussed with the patient. Additional plain radiographs may be ordered after discussion with the referring physician. Regulatory (NRC/state) review and oversight is provided by the physician throughout the procedure

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Gary Dillehay, MD, Kenneth McKusick, MD, Bibb Allen, MD				
Specialty(s):	Society of Nuclear Medicine and American College or Radiology				
CPT Code:	78315				
Sample Size:	488	**Resp n:** 85	**Response:** 17.41 %		
ample Type:	Random				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	0.60	1.00	**1.10**	1.30	10.06
Pre-Service Evaluation Time:			**5.0**		

CPT Code:

Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	9.25	**8.00**	20.00	40.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
/8709	XXX	1.41

CPT Descriptor Kidney imaging with vascular flow and function; multiple studies, with and without pharmacological intervention (eg, angiotensin converting enzyme inhibitor and/or diuretic)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
78707	XXX	0.96

CPT Descriptor 1 Kidney imaging with vascular flow and function; single study without pharmacological intervention

MPC CPT Code 2	Global	Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 27.0 %

TIME ESTIMATES (Median)	CPT Code: 78315	Key Reference CPT Code: 78709
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	8.00	40.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**18.00**	**40.00**
Other time if appropriate Intraservice 78707		22.00

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.46	2.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	2.83
Urgency of medical decision making	3.71	2.35
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.51	3.57
Physical effort required	2.49	2.22
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.29	2.83
Outcome depends on the skill and judgment of physician	3.76	3.52
Estimated risk of malpractice suit with poor outcome	3.27	3.52

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3 24	3.39
Intra-Service intensity/complexity	3.55	3.65
Post-Service intensity/complexity	3.18	3.04

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society of Nuclear Medicine and the American College of Radiology convened a consensus panel to review the random sample AMA RUC survey summary data from the two professional societies. After lengthy discussion it was the consensus of the group that there was no compelling evidence at this time to recommend a change in the RVW value for CPT 78315. We reviewed the codes CPT 78306 and 78315 separately and collectively and concluded there should be no changes in RVW, in order to maintain appropriate rank order. Maintaining them at there current RWVs of 0.86 and 1.02 would maintain them in their rank order with the other bone imaging codes (Bone limited 0.62, bone multiple 0.83,

bone whole body 0.86, bone three phase 1.02, and bone SPECT 1.04). This would also maintain rank order of other comparable radionuclide planar and SPECT imaging for tumor or inflammation, which was an issue when the RUC valued the tumor/radiopharmaceutical distribution codes CPT 78802 and 78804 in 2003.

The rationale to maintain the existing values includes the following:

1. Rank order with the nuclear medicine family of codes.
2. Time data is consistent with other Nuclear Medicine Codes, including CPT 78223 Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function (RVU 0.83, harvard time 22 minutes) and CPT 78585 Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout (RVU 1.09, intra-service 22 minutes), with or without single breath codes with similar RVU values.
3. Comparison to CPT 78707, Kidney imaging with vascular flow and function; single study without pharmacological intervention: MPC A List

Work RVU: 0.96 RVU
Pre-service Time: 0 minutes
Intra-service Time: 22 minutes
Post Service Time: 0 minutes

4. Intensity/complexity measures are similar to the reference service. Both codes represent single day imaging. The value of the reference service was equated to bone scintigraphy because at the time of RUC valuation the survey data was limited (19 responses) and the specialty society consensus panels considered the time over-stated.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 27% No 73%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 23% I do not agree 77%
B. Patients requiring this service are now:
   more complex (more work) 91% less complex (less work) 0% no change 10%
C. The usual site-of-service has changed:

from outpatient to inpatient 9% from inpatient to outpatient 36% no change 55%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:78465 Global Period: XXX Specialty Society RVU: **1.46**

RUC RVU: **1.46**

CPT Descriptor: Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 59-year-old man with hypertension, hypercholesterolemia, and family history of CAD. He has been experiencing several months of occasional chest pressure and shortness of breath on walking. His resting electrocardiogram is abnormal showing sinus rhythm and non-specific ST T wave abnormalities with shallow T wave inversions. He is referred for a stress myocardial perfusion study.

Percentage of Survey Respondents who found Vignette to be Typical: 74%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 98%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the clinical request, pertinent medical records (including cardiac and non cardiac history), x-rays and any prior imaging data to clarify the indications for study and to determine the clinical questions that need to be answered. An interim medical history, including medications and concurrent medical problems, is obtained. The decision is made as to the appropriateness of a myocardial perfusion imaging study or this patient. The physician directs the ordering of an appropriate radiopharmaceutical and dose. Equipment QC , NRC/state regulatory documentation is reviewed.

Description of Intra-Service Work: The physician oversees and directs the prescribed dose that is administered intravenously. The physician directs the technologist to adjust the acquisition protocol and tracer dosing as necessary for the individual patient (the physician is responsible for the oversight of the NRC mandated radiation safety and equipment QC) . He/she is available to answer questions for the technologist or to review components of the study throughout the day. The physician verifies the completeness and adequacy of the data prior to completion of the study and may obtain additional acquisitions as necessary.Tomographic (SPECT) acquisition of a myocardial perfusion tracer is accomplished multiple times (typically stress and rest and/or redistribution) for comparison.

The physician reviews the raw planar spin to assess technical adequacy of data and note extracardiac milieu and patient motion (which may require repeat acquisition). He/she reviews three different view tomographic reconstructions of stress data for defects while cognitively assessing whether findings are technical radiographic or physiologic. Multiple display formats are reviewed and the data is re-reconstructed if necessary. The physician then reviews three view tomographic reconstructions of the rest data set for defects while cognitively assessing whether findings are technical radiographic or physiologic. The physician compares one three-view acquisition dataset to the follow-up three-view dataset for differences or similarities that would suggest ischemia or scar. Qualitative and quantitative measurements of ventricular wall function (or perfusion) are made in a standardized manner for comparison of each dataset, with each segment scored on a semi-quantitative scale. Extent and severity of defects and their relationship to vascular geographic distributions are noted within each of the acquisitions and then compared between acquisitions.

After the qualitative assessment, digital quantification tools are generated. The physician reviews the quantitative tools and utilizes this objective information to reassess and refine the qualitative judgment. More than one digital quantification tool is available for review and the results ejudicated with the visual interpretation.

The physician reviews another two full sets of reconstructed 3-view data that was generated during acquisition with the use of special hardware and software for attenuation correction. This allows further refinement in the assessment of

possible radiographic artifacts. An additional third acquisition of prone imaging may be requested and reviewed to further assess for radiographic attenuation.

A full impression of the study occurs after the integration of the clinical data, independent exercise information, qualitative review, quantitative review, review of special views, and frequently attenuation correction. A formal consultative report is dictated for the medical record.

Description of Post-Service Work: The imaging results are discussed with the referring physician and may be discussed with the patient. The formal report is reviewed and edited as necessary and signed. Regulatory review and oversight (including documentation) for NRC radioisotope handling (including disposal of injection apparatus and wipes /surveys for contamination is provided by the physician).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	William Van Decker, MD, Gary Dillehay, MD, James Blankenship, MD, Bibb Allen, MD					
Specialty(s):	Society of Nuclear Medicine, American College of Cardiology and American College of Radiology					
CPT Code:	78465					
Sample Size:	574	**Resp n:** 125		**Response:** 21.77 %		
Sample Type:	Random					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.80	1.50	**1.70**	1.87	18.00
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		3.00	10.00	**20.00**	25.00	75.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**5.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
78492	XXX	1.87

CPT Descriptor Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
78494	XXX	1.19

CPT Descriptor 1 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

MPC CPT Code 2	Global	Work RVU
70496	XXX	1.75

CPT Descriptor 2 Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 40 **% of respondents:** 32.0 %

TIME ESTIMATES (Median)

	CPT Code: 78465	**Key Reference CPT Code: 78492**
Median Pre-Service Time	5.00	0.00
Median Intra-Service Time	20.00	55.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**30.00**	**55.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.62	3.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.98
Urgency of medical decision making	3.93	3.73

Technical Skill/Physical Effort (Mean)

Technical skill required	3.94	3.98
Physical effort required	2.37	2.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.46	3.10
Outcome depends on the skill and judgment of physician	4.32	4.25
Estimated risk of malpractice suit with poor outcome	3.86	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.88	2.85
Intra-Service intensity/complexity	3.89	3.70
Post-Service intensity/complexity	3.14	3.23

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society of Nuclear Medicine, the American College of Cardiology and the American College of Radiology convened a consensus expert panel to review the random sample AMA RUC survey summary data from the three professional societies. The panel noted that for all 3 codes, survey medians were greater than currently accepted RVU values for these codes. The majority of respondents did not think that work had decreased for these codes over recent years. The majority of respondents agreed that patients were more complex now than in the past. Based on these data, the expert panel considered requesting increases in RVU's, to the level of the survey medians.

However, the expert panel noted that 40 - 72% of survey respondents (depending on the code) reported that the work involved in the procedure had not changed in recent years. The expert panel agreed that the original valuation of these codes was fair and that the survey median RVUs are close enough to current RVUs that there is no compelling reason to request change. Therefore, it was the consensus of the group that there was no compelling evidence at this time to recommend a change to CPT 78465 RVW.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 93015- 93108 stress codes & 78478 & 78480 see summary forms for these codes submitted for this FYR. Stress testing is often performed and coded by a different physician from the one who interprets and codes for nuclear imaging.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 60% No 40%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 29% I do not agree 71%
B. Patients requiring this service are now:
   more complex (more work) 85% less complex (less work) 9% no change 6%
C. The usual site-of-service has changed:
   from outpatient to inpatient 9% from inpatient to outpatient 46% no change 45%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:78478 Global Period: XXX Specialty Society RVU: **0.62**

RUC RVU: **0.50**

CPT Descriptor: Myocardial Perfusion study with wall motion, qualitative or quantitative study (List separately in addition to code for primary procedure)
(Use 78478 in conjunction with 78460, 78461, 78464, 78465)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 64-year-old male smoker with a history of peripheral vascular disease, hypertension and myocardial infarction 7 years ago presents with advancing dyspnea on exertion and occasional chest discomfort. His general internist refers him for myocardial perfusion stress test.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 99%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the existing information, request for exam and relevant clinical data, to clarify the indications for the procedure and to determine the clinical questions to be answered.

Description of Intra-Service Work: The physician assesses the patient's cardiac rhythm. He/she directs the technologist in lead placement for optimal gating signal and any necessary adjustments in gating acquisition parameters based on individual rhythm assessment. The gated portion of the acquisition is frequently performed on both parts of a stress and rest perfusion study (twice) for comparison. The physician may verify the completeness and adequacy of the data prior to completion of the study.

The physician views the completed gated tomographic display data for technical adequacy of interpretation. The images are viewed in multiple display formats, including 3 D reconstruction. The cine image information includes datasets in three views for both the stress and rest portions of the study. The heart motion is qualitatively scored independently for the two parameters of wall motion and endocardial thickening. This occurs in a standardized segment model for each dataset with each segment scored as normal, mildly hypokinetic, moderately hypokinetic, severely hypokinetic, akinetic or dyskinetic. Attention is paid to the assessment of regional myocardial function and to the percent of myocardium that is regionally dysfunctional to elucidate the amount of underlying myocardial scar (or severe ischemia post stress). Quantitative tools of wall motion and wall thickening may be generated and reviewed for each image after the qualitative assessment for refinement of the analysis. The segmental wall motion data is compared to the static flow perfusion images to generate a clinically relevant wall motion analysis for the individual patient. Comparison to previous studies may occur to detect changes. A formal report commenting on regional wall motion and regional thickening is dictated for the medical record. The data is placed into the clinical context of the myocardial perfusion in these regions.

Description of Post-Service Work: The findings are discussed with the referring physician and may be discussed with the patient. The formal report is reviewed and edited as necessary and signed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005
Presenter(s):	William Van Decker, MD, Gary Dillehay, MD, James Blankenship, MD, Bibb Allen, MD
Specialty(s):	Society of Nuclear Medicine, American College of Cardiology and American College of Radiology
CPT Code:	78478

CPT Code:

Sample Size: 574	**Resp n:** 112	**Response:** 19.51 %
Sample Type: Random		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.10	0.50	**0.90**	1.10	14.09
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	0.80	5.00	**5.00**	20.00	75.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
/8472	XXX	0.98

CPT Descriptor Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
78006	XXX	0.49

CPT Descriptor 1 Thyroid imaging, with uptake; single determination

MPC CPT Code 2	Global	Work RVU
78223	XXX	0.84

CPT Descriptor 2 Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 24 **% of respondents:** 21.4 %

TIME ESTIMATES (Median)	**CPT Code: 78478**	**Key Reference CPT Code: 78472**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	5.00	23.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**6.00**	**23.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.14	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.25
Urgency of medical decision making	3.39	3.21

Technical Skill/Physical Effort (Mean)

Technical skill required	3.54	2.50
Physical effort required	2.23	2.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.85	2.75
Outcome depends on the skill and judgment of physician	3.72	3.29
Estimated risk of malpractice suit with poor outcome	3.26	2.71

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.57	2.46
Intra-Service intensity/complexity	3.50	3.13
Post-Service intensity/complexity	2.86	2.54

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society of Nuclear Medicine, the American College of Cardiology and the American College of Radiology convened a consensus expert panel to review the random sample AMA RUC survey summary data from the three professional societies. The panel noted that for all 3 codes, survey medians were greater than currently accepted RVU values for these codes. The majority of respondents did not think that work had decreased for these codes over recent years. The majority of respondents agreed that patients were more complex now than in the past. Based on these data, the expert panel considered requesting increases in RVU's, to the level of the survey medians.

However, the expert panel noted that 40 - 72% of survey respondents (depending on the code) reported that the work involved in the procedure had not changed in recent years. The expert panel agreed that the original valuation of these codes was fair and that the survey median RVUs are close enough to current RVUs that there is no compelling reason to equest change. Therefore, it was the consensus of the group that there was no compelling evidence at this time to recommend a change to CPT 78478 RVW.

Rationale for choice of MPC: Comparison Codes:
We chose XXX global period codes from the MPC list since ZZZ codes were dissimilar in nature to 78478.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

'. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 93015- 93108 stress codes & 78478 & 78480 see summary forms for these codes submitted for this FYR. Stress testing is often performed and coded by a different physician from the one who interprets and codes for nuclear imaging.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 34% No 66%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 43% I do not agree 57%
B. Patients requiring this service are now:
   more complex (more work) 75% less complex (less work) 3% no change 22%
C. The usual site-of-service has changed:
   from outpatient to inpatient 12% from inpatient to outpatient 42% no change 46%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:78480 Global Period: XXX Specialty Society RVU: **.62**

RUC RVU: **0.30**

CPT Descriptor: Myocardial Perfusion study with ejection fraction (List separately in addition to code for primary procedure) (Use 78480 in conjunction with 78460, 78461, 78464, 78465)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 70-year-old female with a history of a heart murmur, diabetes, and hypercholesterolemia presents with increasing exertional dyspnea and chest discomfort. A resting electrocardiogram was abnormal showing sinus rhythm, possible inferior wall myocardial infarction age indeterminate, and non-specific ST T wave abnormalities. She was referred for a myocardial perfusion stress test.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 99%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the existing information, request for exam and relevant clinical data, to clarify the indications for the procedure and to determine the clinical questions to be answered.

Description of Intra-Service Work: The physician assesses the patient's cardiac rhythm. He/she directs the technologist 'n lead placement for optimal gating signal and any necessary adjustments in gating acquisition parameters based on ndividual rhythm assessment. The gated portion of the acquisition is frequently performed on both parts of a stress and rest perfusion study (twice) for comparison. The physician may verify the completeness and adequacy of the data prior to completion of the study.

This study yields mathematically calculated Left Ventricular Ejection Fractions and LV volumes, two prognostic cardiology indicators. Quality studies involve quality LV border detection (may involve physician reprocessing) and the acquisition may need to be repeated in order to avoid adjacent non-cardiac activity that would interfere with those borders.

The physician reviews the display for technical adequacy , as well as for extracardiac artifacts that may impact accuracy, in multiple display formats, including 3 D reconstruction. The physician initially visually estimates ejection fraction. Endocardial borders are constructed by region of interest drawing in both end-diastole and end-systole to calculate LV end diastolic volume and LV end systolic volume and LV ejection fraction. A cognitive assessment needs to be made for which frame is end-diastole and which frame is end-systole. While the computer will attempt to track endocardial borders semi automatically, the physician frequently will have to semi-automatically correct or fully manually interact with the program to correct tracking through the cardiac cycle. This process may be repeated on stress and rest images. The global ejection fraction and LV volumes are compared to the qualitative wall motion and static perfusion images to generate a clinically relevant data point for the individual patient. Comparison to previous studies may occur to detect changes. The physician dictates a report for the medical record.

Description of Post-Service Work: The findings are discussed with the referring physician and may be discussed with the patient. The report is reviewed, edited as necessary and signed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005
Presenter(s):	William Van Decker, MD, Gary Dillehay, MD, James Blankenship, MD, Bibb Allen, MD

Specialty(s):	Society of Nuclear Medicine, American College of Cardiology and American College of Radiology		
CPT Code:	78480		
Sample Size:	574	**Resp n:** 101	**Response:** 17.59 %
Sample Type:	Random		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.10	0.50	**0.75**	0.19	6.00
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	0.00	3.00	**5.00**	10.00	30.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
78496	ZZZ	0.50

CPT Descriptor Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
78006	XXX	0.49

CPT Descriptor 1 Thyroid imaging, with uptake; single determination

MPC CPT Code 2	Global	Work RVU
78223	XXX	0.84

CPT Descriptor 2 Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 24.7 %

TIME ESTIMATES (Median)	**CPT Code: 78480**	**Key Reference CPT Code: 78496**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	5.00	19.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**6.00**	**19.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.74	2.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	2.60
Urgency of medical decision making	2.94	2.80

Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	2.84
Physical effort required	1.88	1.72

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.52	2.28
Outcome depends on the skill and judgment of physician	3.19	3.16
Estimated risk of malpractice suit with poor outcome	2.76	2.48

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.19	2.20
Intra-Service intensity/complexity	2.93	2.96
Post-Service intensity/complexity	2.36	2.96

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The Society of Nuclear Medicine, the American College of Cardiology and the American College of Radiology convened a consensus expert panel to review the random sample AMA RUC survey summary data from the three professional societies. The panel noted that for all 3 codes, survey medians were greater than currently accepted RVU values for these codes. The majority of respondents did not think that work had decreased for these codes over recent years. The majority of respondents agreed that patients were more complex now than in the past. Based on these data, the expert panel considered requesting increases in RVU's, to the level of the survey medians.

However, the expert panel noted that 40 - 72% of survey respondents (depending on the code) reported that the work involved in the procedure had not changed in recent years. The expert panel agreed that the original valuation of these codes was fair and that the survey median RVUs are close enough to current RVUs that there is no compelling reason to equest change. Therefore, it was the consensus of the group that there was no compelling evidence at this time to recommend a change to CPT 78480 RVW.

Rationale for choice of MPC: Comparison Codes:
We chose XXX global period codes from the MPC list since ZZZ codes were dissimilar in nature to 78480.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 93015- 93108 stress codes & 78465, 78464 & 78478 see summary forms for these codes submitted for this FYR. Stress testing is often performed and coded by a different physician from the one who interprets and codes for nuclear imaging.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 28% No 72%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 29% I do not agree 71%
B. Patients requiring this service are now:
   more complex (more work) 70% less complex (less work) 4% no change 26%
C. The usual site-of-service has changed:
   from outpatient to inpatient 11% from inpatient to outpatient 46% no change 43%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:				
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88309 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **3.00**
RUC RVU: **2.80**

CPT Descriptor: Level VI - Surgical pathology, gross and microscopic examination Bone Resection Breast, Mastectomy - with Regional Lymph Nodes Colon, Segmental Resection for Tumor Colon, Total Resection Esophagus, Partial/Total Resection Extremity, Disarticulation Fetus, with Dissection Larynx, Partial/Total Resection - with Regional Lymph Nodes Lung - Total/Lobe/Segment Resection Pancreas, Total/Subtotal Resection Prostate, Radical Resection Small Intestine, Resection for Tumor Soft Tissue Tumor, Extensive Resection Stomach - Subtotal/Total Resection for Tumor Testis, Tumor Tongue/Tonsil - Resection for Tumor Urinary Bladder, Partial/Total Resection Uterus, with or without Tubes and Ovaries, Neoplastic Vulva, Total/Subtotal Resection

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old male presents with rectal bleeding. He undergoes low anterior resection of an adenocarcinoma of the rectum. The pathologist performs the gross and microscopic examination of the specimen and issues a written report of the results.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: Obtaining and reviewing the clinical history and diagnostic studies, including examination of previous study reports and communicating with professionals. Performing examination of specimen; 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; dictation and pathology report preparation; report sign-out with any concurrent telephone communication with other professionals.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Susan E. Spires, MD, W. Stephen Black-Schaffer, MD				
Specialty(s):	College of American Pathologists				
CPT Code:	88309				
Sample Size:	63	**Resp n:** 53	**Response:** 84.1 %		
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	2.40	2.80	**3.00**	3.00	5.00
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		

code88309

Intra-Service Time:		25.00	90.00	**90.00**	100.00	240.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**0.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
88173	XXX	1.39

CPT Descriptor Cytopathology, evaluation of fine needle aspirate; interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99298	XXX	2.75

CPT Descriptor 1 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)

MPC CPT Code 2	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologists

Other Reference CPT Code	Global	Work RVU
88189	XXX	2.23

CPT Descriptor Flow cytometry, interpretation; 16 or more markers

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 28 **% of respondents:** 52.8 %

TIME ESTIMATES (Median)	**CPT Code: 88309**	**Key Reference CPT Code: 88173**
Median Pre-Service Time	0.00	15.00
Median Intra-Service Time	90.00	25.00
Median Immediate Post-service Time	0.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**90.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.07	3.52
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.37	3.11
Urgency of medical decision making	3.67	3.89

Technical Skill/Physical Effort (Mean)

Technical skill required	4.44	2.89
Physical effort required	4.00	2.41

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.93	3.40
Outcome depends on the skill and judgment of physician	4.52	4.04
Estimated risk of malpractice suit with poor outcome	4.22	3.89

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.54	3.30
Post-Service intensity/complexity	0.00	0.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society f Cytopathology (ASC) RUC advisor, representatives from the general pathology community, and members who perform this service. For this review, the workgroup was supplemented by members of CAP's Economic Affairs Committee who have specific expertise with this service. The workgroup's recommendations were then reviewed by an additional 10 pathologists.

The workgroup chose to recommend 3.00 RVW, which represents the median survey response rate. In comparison to the reference code, the recommended RVW of 3.00 represents an increase of 116% above the reference code RVW of 1.39. The survey results support this recommendation as the surveyed time represents an increase of 90% above the total time for the reference code, and the time intensity/complexity measure is 38% greater for 88309 in comparison to he reference code. All of the remaining intensity/complexity measures were higher in comparison to the reference service with the exception of the urgency in medical decision making. In addition, the IWPUT* for the reference code is 0.033, which corresponds to the IWPUT of 0.032 for the surveyed 88309 based on the recommended value and survey time data.

COMPELLING EVIDENCE RATIONALE

The physician work associated with CPT code 88309 has increased significantly, driven by the increase in the number of data elements demanded by current therapeutic regimens for cancer, the emergence and promulgation of the College of American Pathologists' cancer protocols, and the mandated use of the elements of these protocols by cancer programs approved by the Commission on Cancer of the American College of Surgeons. As a result, pathologists have seen an increase in the amount of work required to perform a level VI surgical pathology examination. The increased work for the pathologist in accumulating, synthesizing and documenting these required elements for accurate cancer staging is not acknowledged by the current valuation of the code.

In the past five years, the following issues have contributed to the additional physician work for 88309:

more extensive gross dissection;
increased number of blocks of tissue submitted;
more slides to review;
tumor size measurements in three dimensions;
more margins to assess, localize, and document;

Attached is the Colon and Rectum cancer protocol, which illustrates the reporting elements necessary when a pathologist performs a gross and microscopic examination of a low anterior resection of an adenocarcinoma of the rectum. Prior to the development of the cancer protocols, numbers of lymph nodes dissected were smaller, sampling of nodes was partial, radial margins were often not sampled, grading was sporadic, the mesorectal envelope was not evaluated, lymphocytic response was rarely described, and pathologic staging was generally not performed. The numerous staging elements and periodic updates in staging criteria necessitate that pathologists consult the protocols and staging manuals to ensure the completeness and accuracy of the information now routinely reported.

CAP also reviewed the volume of medical literature on staging of colon cancer; in 1999, for example, there were 106 articles listed in PubMed, as compared to 149 in 2004, representing a 40% increase. This increase reflects the ongoing procedural changes that contribute to the increase in physician work in providing these services.

CAP collected data from two hospitals comparing the reports for 88309 specimens in 1998 and 2005 in one hospital and for 1997 and 2005 in the other. The average number of lines per diagnosis increased from 7.9 to 14.4 (82%) while the median increased from 7.5 to 15 (100%). The average number of lymph nodes examined increased from 13.1 to 18.2 (39%) while the median number increased from 11 to 18 (64%).

*

IWPUT for 88173 RVW 1.39

	Time	Intensity	(=time x intensity)
Pre-Service	15	0.0224	0.336
Post-Service	10	0.0224	0.224
Intra-Service	25		

Intra-service RVW: (1.39) – (0.336 + 0.224) = 0.83
IWPUT: 0.83/25 minutes = 0.033

IWPUT for 88309 Recommended RVW 3.00

Time
Intra-Service 95

WPUT: 3.00/95 minutes = 0.032

Attachment

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 98% No 2%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 4% I do not agree 96%
B. Patients requiring this service are now:
   more complex (more work) 98% less complex (less work) 0% no change 2%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 2% no change 98%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 88309

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88321 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **2.00**
RUC RVU: **1.63**

CPT Descriptor: Consultation and report on referred slides prepared elsewhere

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old female presents with a soft tissue mass of the posterior neck. Biopsy reveals a tumor composed of monotonous blue cells upon routine microscopic examination. A panel of immunohistochemical stains is not conclusive as to the lineage of the tumor. The routine microscopic slides and immunohistochemical stains are referred for consultation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: Obtaining and reviewing the clinical history and referral information, including referral letter and results of additional clinical testing. Reviewing report of gross examination; communication as necessary with referring pathologist on gross findings and block designations; interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; determination if additional workup is necessary; any review of literature or research during examination of the test result; dictation and pathology report preparation; report sign-out with any concurrent telephone communication with other professionals.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Susan E. Spires, MD, W. Stephen Black-Schaffer, MD					
Specialty(s):	College of American Pathologists					
CPT Code:	88321					
Sample Size:	54	**Resp n:** 43		**Response:** 79.6 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.39	1.63	**1.90**	2.00	2.80
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		40.00	50.00	**50.00**	60.00	100.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**0.00**					

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
88173	XXX	1.39

CPT Descriptor Cytopathology, evaluation of fine needle aspirate; interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
71275	XXX	1.92

CPT Descriptor 1 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

MPC CPT Code 2	Global	Work RVU
93312	XXX	2.20

CPT Descriptor 2 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretatoin and report

Other Reference CPT Code	Global	Work RVU
88189	XXX	2.23

CPT Descriptor Flow cytometry, interpretation; 16 or more markers

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 60.4 %

TIME ESTIMATES (Median)

	CPT Code: 88321	Key Reference CPT Code: 88173
Median Pre-Service Time	0.00	15.00
Median Intra-Service Time	50.00	25.00
Median Immediate Post-service Time	0.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**50.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.50	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.46	3.30
Urgency of medical decision making	3.96	3.81

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.46
Physical effort required	2.92	2.69

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.15	3.38
Outcome depends on the skill and judgment of physician	4.69	4.19
Estimated risk of malpractice suit with poor outcome	4.54	3.88

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.44	3.44
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general pathology community, and members who perform this service. For this review, the workgroup was supplemented by members of CAP's Economic Affairs Committee who have specific expertise with this service. The workgroup's recommendations were then reviewed by an additional 10 pathologists.

The workgroup chose to recommend 2.00 RVW, which represents the 75th percentile survey response rate. The 88321 survey time represents an increase of 20% above the reference code total time, with a 29% increase in the intraservice intensity/complexity time segment. The recommended RVW of 2.00 represents an IWPUT* of 0.033, which is the same as the reference code. A lower IWPUT, which the median would impose, would be inconsistent with the survey lata.

COMPELLING EVIDENCE RATIONALE

The College recommended 88321 for the five-year review as the complexity and content of the code has substantively increased in the past five years. Immunohistochemistry and other ancillary studies are now widely available to community pathologists. Prior to this availability, the typical case referred for consultation included H&E slides, sometimes with paraffin blocks, sent to large academic centers that had access to esoteric diagnostic modalities, which at that time were not generally available to community pathologists. Now, community pathology laboratories are typically able to perform the immunohistochemistry and other ancillary special studies that allow for the diagnosis of the more straightforward cases. Only more difficult cases not resolvable by these sophisticated studies are referred for consultation. Such cases require subtler delineation of numerous diagnostic entities currently recognized as clinically distinct that were not previously described or distinguishable.

CAP collected data from an academic pathology practice, comparing 88321-consultation cases in 2001 with those in 2005. In 2001, the average case received comprised 6.9 H&E slides, 60.4% submitted with no accompanying immunohistochemical stains, 39.6% with one such stain, and none sent with more than one. In 2005, the average case received comprised 8.2 H&E slides and only 39.2% were sent with no accompanying immunohistochemical stains, 23.5% with one, 9.8% with two, and 27.5% with more than two such stains.

Another academic practice compared the number of H&E slides and the number of diagnostic lines reported per 88321-consultation in two time periods, from 1995 through 1999, and in 2005:

	1995-1999	2005
Average slides received per 88321	4.6	8.8
Median slides received per 88321	4	6
Average diagnostic lines per 88321	7.4	12.7
Median diagnostic lines per 88321	6	11

*

IWPUT for 88173 RVW 1.39

	Time	Intensity	(=time x intensity)
Pre-Service	15	0.0224	0.336
Post-Service	10	0.0224	0.224
Intra-Service	25		

Intra-service RVW: (1.39) - (0.336 + 0.224) = 0.83
IWPUT: 0.83/25 minutes = 0.033

IWPUT for 88321 Recommended RVW 2.00

Time	
Intra-Service	60

WPUT: 2.00/60 minutes = 0.033

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 98% No 2%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 5% I do not agree 95%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 10% no change 90%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 88321

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:				
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88323 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **2.31**
RUC RVU: **1.83**

CPT Descriptor: : Consultation and report on referred material requiring preparation of slides

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old male presents with symptoms of urinary tract obstruction. He undergoes transurethral resection of the prostate. On evaluation, atypical foci are found in two chips of tissue. Immunohistochemical stains for p63, CKHMW and P504s are inconclusive. The case, including slides and blocks, is referred for expert consultation. After examining the initial submission, the consultant pathologist has additional deeper sections cut from the blocks containing the questionable foci.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: Obtaining and reviewing the clinical history and referral information, including referral letter and results of additional clinical testing. Reviewing report of gross examination; communication as necessary with referring pathologist on gross findings and block designations; interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; determination if additional workup is necessary; review of additional deeper block sections; any review of literature or research during examination of the test result; dictation and pathology report preparation; report sign-out with any concurrent telephone communication with other professionals.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Susan E. Spires, MD, W. Stephen Black-Schaffer					
Specialty(s):	College of American Pathologists					
CPT Code:	88323					
Sample Size:	54	**Resp n:** 46		**Response:** 85.1 %		
Sample Type:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	1.45	1.83	**2.15**	2.48	2.90	
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	20.00	56.00	**56.00**	75.00	100.00	
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**0.00**					

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
38173	XXX	1.39

CPT Descriptor Cytopathology, evaluation of fine needle aspirate; interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
93312	XXX	2.20

CPT Descriptor 1 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretatoin and report

MPC CPT Code 2	Global	Work RVU
99298	XXX	2.75

CPT Descriptor 2 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)

Other Reference CPT Code	Global	Work RVU
88189	XXX	2.23

CPT Descriptor Flow cytometry, interpretation; 16 or more markers

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 23 **% of respondents:** 50.0 %

TIME ESTIMATES (Median)	CPT Code: 88323	Key Reference CPT Code: 88173
Median Pre-Service Time	0.00	15.00
Median Intra-Service Time	56.00	25.00
Median Immediate Post-service Time	0.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**56.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.45	3.45
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.68	3.23
Urgency of medical decision making	3.95	3.77

Technical Skill/Physical Effort (Mean)

Technical skill required	4.32	3.36
Physical effort required	2.91	2.59

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.05	3.36
Outcome depends on the skill and judgment of physician	4.71	4.23
Estimated risk of malpractice suit with poor outcome	4.62	3.95

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.36	3.48
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general pathology community, and members who perform this service. For this review, the workgroup was supplemented by members of CAP's Economic Affairs Committee who have specific expertise with this service. The workgroup's recommendations were then reviewed by an additional 10 pathologists.

In order to avoid a rank order anomaly in the family of codes, 2.31 RVW was recommend. This value represents the approximate midpoint between the median and 75th percentile responses. The median response of 2.15 RVU would have resulted in an IWPUT* of 0.031 for 88323, in comparison to the reference code with an IWPUT of 0.033. A recommendation of 2.31 RVW results in an IWPUT of 0.033, identical to the reference code and to 88321. In addition, physician times and intensity survey data are communsurate with this value.

COMPELLING EVIDENCE RATIONALE

The College recommended 88323 for inclusion in the five-year review as the complexity and content of the consultation has substantively increased in the past five years for the same reasons as for 88321. Immunohistochemistry and other ancillary studies are now widely available to community pathologists. Prior to this availability, the typical case referred for consultation included H&E slides, sometimes with paraffin blocks, sent to large academic centers that had access to esoteric diagnostic modalities, which at that time were not generally available to community pathologists. Now, community pathology laboratories are typically able to perform the immunohistochemistry and other ancillary special studies that allow for the diagnosis of the more straightforward cases. Only more difficult cases not resolvable by these sophisticated studies are referred for consultation. Such cases require subtler delineation of numerous diagnostic entities currently recognized as clinically distinct that were not previously described or distinguishable.

CAP collected data from an academic pathology practice, comparing 88321-consultation cases in 2001 with those in 2005. In 2001, the average case received comprised 6.9 H&E slides, 60.4% submitted with no accompanying immunohistochemical stains, 39.6% with one such stain, and none sent with more than one. In 2005, the average case received comprised 8.2 H&E slides and only 39.2% were sent with no accompanying immunohistochemical stains, 23.5% with one, 9.8% with two, and 27.5% with more than two such stains.

Another academic practice compared the number of H&E slides and the number of diagnostic lines reported per 88321-consultation in two time periods, from 1995 through 1999, and in 2005:

	1995-1999	2005
Average slides received per 88321	4.6	8.8
Median slides received per 88321	4	6
Average diagnostic lines per 88321	7.4	12.7
Median diagnostic lines per 88321	6	11

88323 differs from 88321 in that additional routine slides are prepared and examined by the consultant as part of the 88323 service. The additional work value represents the examination of this additional material. The underlying premises justifying the request for increased valuation are the same as for 88321.

*

IWPUT for 88173 RVW 1.39

	Time	Intensity	(=time x intensity)
Pre-Service	15	0.0224	0.336
Post-Service	10	0.0224	0.224
Intra-Service	25		

Intra-service RVW: (1.39) - (0.336 + 0.224) = 0.83
IWPUT: 0.83/25 minutes = 0.033

IWPUT for 88323 Recommended RVW 2.31

	Time
Intra-Service	70

IWPUT: 2.31/70 minutes = 0.033

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example .05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 96% No 4%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 5% I do not agree 95%
B. Patients requiring this service are now:
   more complex (more work) 98% less complex (less work) 0% no change 2%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 5% no change 95%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 88323

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:88325 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **2.93**
RUC RVU: **2.50**

CPT Descriptor: Consultation, comprehensive, with review of records and specimens, with report on referred material

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female presents with atypical breast calcifications on screening mammogram. She undergoes needle localization with excisional biopsy. The pathologist's differential diagnosis is ductal carcinoma-in-situ (DCIS) versus invasive ductal carcinoma. Slides including immunohistochemical stains for p63 and calponin, and medical records including operative report, mammogram and mammography report, are referred for consultation.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: none

Description of Intra-Service Work: Obtaining and reviewing the clinical history and referral information, including referral letter; radiographic reports and results of additional clinical testing. Reviewing report of gross examination; communication as necessary with referring pathologist on gross findings and block designations; interpretation of the test result; comparison to previous study reports; consideration of relevant statistical variations; identification of clinically meaningful findings; review of submitted radiographs and correlation with block and section designations; determination if additional workup is necessary; any review of literature or research during examination of the test result; dictation and pathology report preparation; report sign-out with any concurrent telephone communication with other professionals.

Description of Post-Service Work: none

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Susan E. Spires, MD, W. Stephen Black-Schaffer,MD					
Specialty(s):	College of American Pathologists					
CPT Code:	88325					
Sample Size:	44	**Resp n:** 36		**Response:** 81.8 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.70	2.50	**2.79**	2.93	4.50
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		45.00	80.00	**80.00**	100.00	155.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**0.00**					

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
88173	XXX	1.39

CPT Descriptor Cytopathology, evaluation of fine needle aspirate; interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99298	XXX	2.75

CPT Descriptor 1 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)

MPC CPT Code 2	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologists

Other Reference CPT Code	Global	Work RVU
88189	XXX	2.23

CPT Descriptor Flow cytometry, interpretation; 16 or more markers

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 41.6 %

TIME ESTIMATES (Median)

	CPT Code: 88325	Key Reference CPT Code: 88173
Median Pre-Service Time	0.00	15.00
Median Intra-Service Time	80.00	25.00
Median Immediate Post-service Time	0.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**80.00**	**50.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.40	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.87	3.20
Urgency of medical decision making	3.90	3.70

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.33
Physical effort required	3.00	2.73

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	3.67
Outcome depends on the skill and judgment of physician	4.80	4.30
Estimated risk of malpractice suit with poor outcome	4.67	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity	4.62	3.14
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Following the survey, the data were reviewed by CAP's relative value workgroup which includes the American Society of Cytopathology (ASC) RUC advisor, representatives from the general pathology community, and members who perform this service. For this review, the workgroup was supplemented by members of CAP's Economic Affairs Committee who have specific expertise with this service. The workgroup's recommendations were then reviewed by an additional 10 pathologists.

The workgroup chose to recommend 2.93 RVW, which represents the 75th percentile survey response rate. The recommendation results in an IWPUT* of 0.033 which is the same as the other two codes in this family, avoiding a rank order anomaly. In further comparison to the reference code, which also has an IWPUT of 0.033, the intensity/complexity measures of the surveyed service were higher in comparison to the reference service in all areas. In addition, physician times and intensity survey data are commensurate with this value.

COMPELLING EVIDENCE RATIONALE

The College recommended 88325 for inclusion in the five-year review as the complexity and content of the consultation has substantively increased in the past five years for. The reasons for the increased work follows the same rationale as for 88321 and 88323. Immunohistochemistry and other ancillary studies are now widely available to community pathologists. Prior to this availability, the typical case referred for consultation included H&E slides, sometimes with paraffin blocks, sent to large academic centers that had access to esoteric diagnostic modalities, which at that time were not generally available to community pathologists. Now, community pathology laboratories are typically able to perform the immunohistochemistry and other ancillary special studies that allow for the diagnosis of the more straightforward cases. Only more difficult cases not resolvable by these sophisticated studies are referred for consultation. Such cases require subtler delineation of numerous diagnostic entities currently recognized as clinically distinct that were not previously described or distinguishable.

CAP collected data from an academic pathology practice, comparing 88321-consultation cases in 2001 with those in 2005. In 2001, the average case received comprised 6.9 H&E slides, 60.4% submitted with no accompanying immunohistochemical stains, 39.6% with one such stain, and none sent with more than one. In 2005, the average case received comprised 8.2 H&E slides and only 39.2% were sent with no accompanying immunohistochemical stains, 23.5% with one, 9.8% with two, and 27.5% with more than two such stains.

Another academic practice compared the number of H&E slides and the number of diagnostic lines reported per 88321-consultation in two time periods, from 1995 through 1999, and in 2005:

	1995-1999	2005
Average slides received per 88321	4.6	8.8
Median slides received per 88321	4	6
Average diagnostic lines per 88321	7.4	12.7
Median diagnostic lines per 88321	6	11

88325 differs from 88321 in that it requires the review of medical records other than pathology reports as part of the consultation. In some cases, it may also require the preparation and examination of additional slides. The increase in work value for this code represents the additional work of such record review and the fact that consultations requiring such review are generally more difficult. The underlying premises justifying the request for increased valuation are the same as for 88321.

*

IWPUT for 88173 RVW 1.39

	Time	Intensity	(=time x intensity)
Pre-Service	15	0.0224	0.336
Post-Service	10	0.0224	0.224
Intra-Service	25		

Intra-service RVW: (1.39) - (0.336 + 0.224) = 0.83
IWPUT: 0.83/25 minutes = 0.033

IWPUT for 88323 Recommended RVW 2.31

Time	
Intra-Service	70

IWPUT: 2.31/70 minutes = 0.033

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

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ive-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 97% No 3%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 6% I do not agree 94%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 14% no change 86%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 88325

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93010 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **.24**
RUC RVU: **.17**

CPT Descriptor: Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 55-year-old man presents to his internist's office for complaints of one month of exertional chest pain. After a focused visit and examination, the patient is sent to the laboratory for an electrocardiogram (ECG). The ECG is performed by the technician and held for the cardiologist to interpret and complete a report of his/her findings.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 100%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
-Review medical records and chart
-Determine clinical questions to be answered

Description of Intra-Service Work:

- Physician obtains ECG directly from technician and/or goes to ECG reading room to acquire 12 lead ECG
- Physician reviews and compares one or more previous ECG's with the current ECG
- Physician reviews and compares ECG reading adjusting for age, weight, known cardiac diagnosis and presence or absence of electronic cardiac devices
- ECG is inspected for rhythm which includes - diagnosis of atrial rhythm, diagnosis of ventricular rhythm, and the summation of those two rhythms as the patients intrinsic rhythm as it related to the ECG
- Primary intervals are visually inspected and then compared with computer generated intervals and the previous ECG intervals. (these intervals include: PR, QRS duration, QT duration, and others)
- Physician compares and analyzes the P wave morphology and P wave axis, the QRS morphology and associated axis
- Physician analyzes QRS morphology in relation to previous infarction, recent infarction, a change in morphology in comparison to previous ECG, criteria for hypertension and hypertrophy.
- Physician carefully inspects each tracing for the presence or absence of pacemaker artifacts
- Physician then identifies and describes the presence or absence of atrial and or ventricular
- Physician then compares his ECG diagnosis with that obtained from computer ECG diagnosis, deletes and or includes appropriate diagnosis.
- Physician then dictates, writes, and or confirms his interpretation with that of a computer generated interpretation

Description of Post-Service Work:

-Discuss findings with the referring physician
-Discuss findings with the patient
Review report, edit as necessary and sign
Review and store ECG for future reference

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	James Maloney, M.D., F.A.C.C., James Blankenship, M.D., F.A.C.C.					
Specialty(s):	American College of Cardiology					
CPT Code:	93010					
Sample Size:	300	**Resp n:** 31		**Response:** 10.3 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.15	0.24	**0.30**	0.50	2.00	
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	0.00	3.00	**4.00**	5.00	10.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**1.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
72050	XXX	0.31

CPT Descriptor Radiologic examination, spine, cervical; minimum of four views

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99211	XXX	0.17

CPT Descriptor 1 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.

MPC CPT Code 2	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 2 examination, knee; one or two views

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 16.1 %

TIME ESTIMATES (Median)	**CPT Code: 93010**	**Key Reference CPT Code: 72050**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	4.00	8.00
Median Immediate Post-service Time	1.00	0.00
Median Critical Care Time		0.00
Median Other Hospital Visit Time		0.00
Median Discharge Day Management Time		0.00
Median Office Visit Time		0.00
Median Total Time	**5.00**	**8.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.60
Urgency of medical decision making	3.00	3.60

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.20
Physical effort required	1.50	1.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.40
Outcome depends on the skill and judgment of physician	3.00	3.60
Estimated risk of malpractice suit with poor outcome	3.00	3.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.00	2.40
Intra-Service intensity/complexity	3.00	3.40
Post-Service intensity/complexity	2.00	2.40

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel consisting of members of the American College of Cardiolgy's Cardiovascular Relative Value Update Committee met by teleconference to review survey data for code 93010.

The Panel noted that the RUC database contains a RUC time of 7 minutes from 1995, including 5 intra- and 2 post-minutes. The current survey median times were the same for intra- (5 minutes) and for post- (2 minutes) work. Survey respondents also included 2 minutes of pre-time.

The Panel agreed that the survey median RVU of 0.3 seemed high for this code, and suggested that survey respondents' estimate of time (9 minutes) was probably too high for this service. The 1995 estimate of 7 minutes total time seemed more appropriate. The Panel subtracted from 0.3 an amount equal to 2/9ths of 0.3 (= 0.06 RVU) and arrived at 0.24, which was exactly the 25th per centile survey RVU.

Work per Time: The total work per total time is 0.24/7 = .034 (or if one uses 9 minutes it would be .027). Recognizing that work per unit time has not been validated for brief procedures and is controversial, these numbers seemed at least reasonable. For example, work per time for the most frequently chosen reference code 72050 is .039.

Comparison to Reference Codes 72050: The Panel compared 93010 to the most frequently chosen reference code, 72050 (x-ray, c-spine, 4 views, RVU = .31, Harvard time = 8 minutes). Intensity measures for 93010 were about 3/4ths those for 72050, and multiplying 93010's survey median of 0.3 by 3/4ths yields 0.225, supporting the 25th per centile value of .24.

Comparison to other MPC List RUC-Surveyed Codes:
99211: Office E&M service that may not require the presence of a physician (RUC time = 7 minutes, 0.17 RVU). The Panel reasoned that 93010 required more work at greater intensity than a service for which the physician was not even present, supporting a value significantly above 0.17.
73560: knee x-ray, 1 or 2 views (RUC time 3 minutes, RVU = 0.17). The Panel noted that the survey time for 93010 (9 minutes) was 3 times that for 73560, supporting an RVU value much higher than 0.17.

Comparison to EKG-Type Codes:
93040: rhythm EKG, 1 to 3 leads, with report (Harvard time 3 minutes, RVU = 0.16). The Panel noted that 93010's urvey time was 3 times as long as 93040, supporting a value much higher than 0.16.
93224: EKG monitoring 24 hours with report (Harvard time 16 minutes, RVU = 0.52). If work per time is the same for 93010 and 93224, 93010 should have 7/16ths of 0.52 = 0.228 RVU or 9/16ths of 0.52 = 0.29.

Compelling Evidence for Change: After considering all of the above data, the Panel determined that there is compelling evidence for an increase in the RVUs for 93010.

The Panel noted that the work of 93010 has increased over the prior 10 years. Automated retrieval systems make it possible to retrieve prior EKGs more frequently, and the typical patient has at least one and often several EKG's, all of which must be separately interpreted by the physician and compared to the current EKG. All survey respondents agreed that the typical patient is more complex due to the increased incidence of pacemakers, ICD's, and survival after cardiac events.

The Panel agreed that comparisons to the most frequently chosen reference service, to other MPC List codes, and to similar EKG-type codes all suggest that 93010 has been previously undervalued. Even allowing for some over-estimation of time and work by survey respondents, the survey provides powerful evidence that the appropriate value of 93010 is about 50% higher than the current value. While the absolute difference in RVU is small, the % difference is large and warrants correction.

SERVICES REPORTED WITH MULTIPLE CPT CODES

Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: yes

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- x Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 13% No 87%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: _____

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:93015 Global Period: XXX Specialty Society RVU: **1.00**

RUC RVU: .75

CPT Descriptor: Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 49-year-old male with hypertension, active lifestyle, high cholesterol, prior cigarette use with occasional chest discomforts during exercise. His office resting ECG is normal.The ECG is performed by the technician and held for the cardiologist to interpret and complete a report of his/her findings.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review medical records and chart
- Determine clinical questions to be answered

Description of Intra-Service Work:
- Assess new symptoms
- Assess pharmacologic stress versus treadmill
- Answer patient questions for obtaining informed consent
- Supervise pharmacologic medication stress infusion if necessary
- Assess adequacy of data collection
- Treat arrhythmias, ischemic responses, hypo- or hypertension, or other untoward medical events
- Treat non cardiac side effects of pharmacologic stress testing
- Interpret resting ECG.
- Interpret multiple serial ECG's for timing, morphology, and degree of ST segment changes and timing of ST segment resolution
- Review and analyze for reporting purposes: starting and ending hemodynamics, arrhythmias, symptoms (especially chest pain), and functional capacity
- Dictate a report for the medical record including whether study is positive , negative , or non diagnostic for ischemic response.

Description of Post-Service Work:
- Review, edit, sign report
- Discuss critical abnormal values with patient
- Discuss with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Willaim Van Decker, MD, James Blankenship, MD				
Specialty(s):	American College of Cardiology				
CPT Code:	93015				
Sample Size: 86	**Resp n:** 43	**Response:** 50 %			
Sample Type:	Random				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.40	0 75	**1.00**	1.30	3.00
Pre-Service Evaluation Time:			**2.00**		
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:	0.00	10.00	**15.00**	20.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**4.00**	
Critical Care time/visit(s):	_____	99291x 99292x
Other Hospital time/visit(s):	_____	99231x 99232x 99233x
Discharge Day Mgmt:	_____	99238x 99239x
Office time/visit(s):	_____	99211x 12x 13x 14x 15x

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
93350	XXX	1.48

CPT Descriptor Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
93307	XXX	0.92

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

MPC CPT Code 2	Global	Work RVU
78494	XXX	1.19

CPT Descriptor 2 Cardiac blood pool imaging, gated equilibrium, SPECT, at rest, wall motion study plus ejection fraction, with or without quantitative processing

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 25.6 %

TIME ESTIMATES (Median)	**CPT Code: 93015**	**Key Reference CPT Code: 93350**
Median Pre-Service Time	2.00	0.00
Median Intra-Service Time	15.00	40.00
Median Immediate Post-service Time	4.00	0.00
Median Critical Care Time		0.00
Median Other Hospital Visit Time		0.00
Median Discharge Day Management Time		0.00
Median Office Visit Time		0.00
Median Total Time	**21.00**	**40.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.27
Urgency of medical decision making	4.00	3.36

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.82
Physical effort required	2.00	2.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.18
Outcome depends on the skill and judgment of physician	3.00	3.82
Estimated risk of malpractice suit with poor outcome	3.00	3.36

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.36
Intra-Service intensity/complexity	3.00	4.00
Post-Service intensity/complexity	3.00	2.64

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel reviewed survey data for 93015. The panel noted that the Survey median RVU was 1.0, the 25th per centile was 0.75, and the lowest RVU was 0.40. The Panel noted that the Harvard time was 21 minutes, compared to the survey time of 25 minutes. The Panel agreed that 1.0 generally seemed to be a reasonable value for 93018 compared to the codes in CPT.

The Panel noted that survey respondents uniformly agreed that currently patients are more complex causing more work compared to years ago. The Panel agreed, noting that pharmacologic stress is more frequent and is the typical type of stress test at some institutions. Pharmacologic stress tests require closer physician supervision, more frequent physician intervention to induce pharmacologic stress, more frequent physician involvement in diagnosing side effects of the drugs used to stress the hearrt, and more frequent physician administration of medications to counteract symptoms caused by stress-inducing drugs. All of these have increased the work required for many or most patients.

Comparison to Reference Code: 93350, stress echo, has RVU = 1.48 and 40 minutes. The survey for 93015 provided a median of 1.0 RVU and 25 minutes. Intensity/complexity measures are similar for the 2 codes, so we can calculate 25/40 x 1.48 = 0.93 as the RVU value for 93015, which supports the survey median of 1.0.

Building Block Approach: The survey for 93018 suggests a median RVU of 0.6 and time of 12 minutes. Subtracting the time and RVUs of 93018 from those of 93015 yields 13 minutes and 0.4 RVU for the physician supervision of the stress test (apart from interpretation and reporting of EKG's). This is appropriate when compared to other codes requiring physiologic monitoring during provocation. For example, 93024, ergonovine stress testing has 34 Harvard minutes and 1.17 RVU. The ratio of RVU/minutes for 93024 (0.0344) is similar to the ratio for physician supervision above, which is 0.4/13 minutes = 0.0307.

Compelling Evidence for Change: The panel noted that the survey median is only 33% greater than the current RVU for 93015 and questioned whether there is a compelling reason to change the current RVU. The panel agreed that the work of the procedure has increased, that the survey data appears good and suggests the current RVU is undervalued, and that the support of the survey median by comparison to 2 similar codes constitutes compelling evidence to change the current value.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: no

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example .05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 33% No 67%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 7% I do not agree 93%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 7% from inpatient to outpatient 57% no change 36%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 93015

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93018 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.30**
RUC RVU: **0.30**

CPT Descriptor: Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 49-year-old male with hypertension, active lifestyle, high cholesterol, prior cigarette use with occasional chest discomforts during exercise. His office resting ECG is normal.

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review medical records and chart
- Determine clinical questions to be answered

Description of Intra-Service Work:
- Assess adequacy of data acquisition
- Interpret resting ECG

Interpret multiple serial ECG's for timing, morphology, and degree of ST segment changes and timing of ST segment resolution
- Review and analyze for reporting purposes: starting and ending hemodynamics, arrhythmias, symptoms (especially chest pain) , and functional capacity
- Dictate a report for the medical record including whether study is positive, negative, or non diagnostic for ischemic response.

Description of Post-Service Work:

- Review, edit, sign report
- Discuss critical abnormal values with patient
- Discuss with referring physician

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Willaim Van Decker, MD, James Blankenship, MD					
Specialty(s):	American College of Cardiology					
CPT Code:	93018					
Sample Size:	86	**Resp n:** 43		**Response:** 50 %		
Sample Type:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.30	0.52	**0.60**	0.93	1.98	
Pre-Service Evaluation Time:			**2.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	0.00	5.00	**5.00**	10.00	30.00	

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	_____	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	_____	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	_____	99238x **0.00** 99239x **0.00**
Office time/visit(s):	_____	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
93230	XXX	0.52

CPT Descriptor Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage without superimposition scanning utilizing a device capable of producing a full miniaturized printout; includes recording, microprocessor-based analysis with report, physician review and interpretation

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
78006	XXX	0.49

CPT Descriptor 1 Thyroid imaging, with uptake; single determination

MPC CPT Code 2	Global	Work RVU
76700	XXX	0.81

CPT Descriptor 2 Ultrasound, abdominal, B-scan and/or real time with image documentation; complete

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 48.8 %

TIME ESTIMATES (Median)	**CPT Code: 93018**	**Key Reference CPT Code: 93230**
Median Pre-Service Time	2.00	0.00
Median Intra-Service Time	5.00	16.00
Median Immediate Post-service Time	5.00	0.00
Median Critical Care Time		0.00
Median Other Hospital Visit Time		0.00
Median Discharge Day Management Time		0.00
Median Office Visit Time		0.00
Median Total Time	**12.00**	**16.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.40
Urgency of medical decision making	3.00	2.35

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.90
Physical effort required	1.00	1.35

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	1.80
Outcome depends on the skill and judgment of physician	3.00	2.65
Estimated risk of malpractice suit with poor outcome	3.00	2.25

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.00	1.40
Intra-Service intensity/complexity	3.00	2.70
Post-Service intensity/complexity	2.50	1.70

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

An expert panel reviewed survey data for 93018. The panel noted that the Survey median RVU was 0.6, the 25th per centile was 0.52, and the lowest RVU was 0.3, equal to the current RVU for this code. The Panel noted that all but 1 survey respondent felt that 93018 was undervalued, and Panel agreed. The Panel noted that the Harvard time was 14 minutes, compared to the survey time of 12 minutes. The Panel agreed that 0.6 generally seemed to be a reasonable value for 93018 compared to the codes in CPT.

Comparison to Reference Code: The Panel compared 93018 to the most frequently chosen reference code, 93230. The panel noted that the three 24-hour EKG monitoring codes (93230, 93224, 93227) are all valued at 0.52 and all have 16 minutes of Harvard time. The Panel noted that survey respondents reported that complexity/intensity measures were higher for 93018 than for the reference code. This difference in intensity/complexity supports the survey finding of a higher RVU (0.6 RVU) and less time for 93018 compared to 93230.

Comparison to Similar Code: 93010 (EKG) includes the work of reading a 12-lead EKG and comparing it to previous EKGs (RVU = 0.17 or 0.30, time = 7 minutes). In contrast, 93018 includes the work of reading the baseline EKG, additional EKGs at 1 minute intervals (usually 5 - 10 of them), the recovery EKGs for up to 10 minutes, and any arrhythmias that occur during the 5 - 20 minutes of total monitoring time. The Panel estimated that this represents at least twice the work of the 93010, yielding an estimate of at least 0.34 RVUs (based on the current value of 93010) to 0.6 RVUs (based on the 5-year review Specialty recommendation for 93010).

Compelling Evidence for Change: The Panel finally considered whether there was compelling evidence that the value of 93018 should be changed. The Panel agreed with survey respondents that patients were more complex now compared to years ago. The Panel concluded that the survey median RVU which is twice the current value supported by favorable comparisons to two other codes indicate that the current value is significantly undervalued and should be corrected.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 27% No 73%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 18% I do not agree 82%
B. Patients requiring this service are now:
   more complex (more work) 82% less complex (less work) 0% no change 18%
C. The usual site-of-service has changed:

from outpatient to inpatient 9% from inpatient to outpatient 55% no change 36%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 93018

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94010 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.17**
RUC RVU: **0.17**

CPT Descriptor: Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman complains of shortness of breath, with occasional wheezing. Spirometry is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
* The pre-service work is different from the work of an Evaluation and Management Service where the determination is made that spirometry be performed. Spirometry is performed in a separate room from an E/M Service.
* Data is input in the computer to identify the patient. The technologist calibrates the equipment and prepares the supplies, greets the patient, verifies that inhaled medications have been withheld, obtains vital signs, positions the patient and provides instructions to the patient on how to perform the spirometry test. The test is repeated a minimum of three times, and up to eight times, in order to achieve at least two acceptable and repeatable sets of values (in accord with the ATS/ERS Consensus Statement.)

Description of Intra-Service Work:
* The physician evaluates the data to ensure accuracy, including review of the mid-maximal flow rates, examination of the flow-time curves, and comparision to available previous studies for significant interval change according to the ATS/ERS Consensus Statement.
* The physician interprets the results and writes a report.

Description of Post-Service Work:
* The physician documents the results in the medical record.
* The physician discusses the results with the patient/family, and communicates the results to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Alan Plummer, MD, ATS and Edward Diamond, MD, ACCP				
Specialty(s):	Pulmonary				
CPT Code:	94010				
Sample Size:	170	**Resp n:** 30	**Response:** 17.64 %		
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.17	0.31	**0.31**	0.44	1.40
Pre-Service Evaluation Time:			**0.0**		
Pre-Service Positioning Time:			**0.0**		

Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		0.00	4.50	**5.00**	12.50	45.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**2.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
94375	XXX	0.31

CPT Descriptor Respiratory flow volume loop

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
94060	XXX	0.31

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

MPC CPT Code 2	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU
94060	XXX	0.31

CPT Descriptor Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 46.6 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 94010	Key Reference CPT Code: 94375
Median Pre-Service Time	0.00	5.00
Median Intra-Service Time	5.00	7.00
Median Immediate Post-service Time	2.00	5.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0 0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**7.00**	**17.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.79	2.64
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.36
Urgency of medical decision making	2.36	2.36

Technical Skill/Physical Effort (Mean)

Technical skill required	2.50	2.50
Physical effort required	1.93	1.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.36	1.29
Outcome depends on the skill and judgment of physician	2.57	2.50
Estimated risk of malpractice suit with poor outcome	1.71	1.63

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1 79	1.71
Intra-Service intensity/complexity	2.07	2.00
Post-Service intensity/complexity	2.00	2.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The survey data was collected online with SurveyMonkey. The American Thoracic Society's Clinical Practice Committee reviewed the data at their July 8, 2005 monthly meeting. The American College of Chest Physicians Practice Management Committee reviewed the data at their July 11, 2005 meeting. Final Consensus was achieved through email confirmation of the completed Summary of Recommendation form. The survey responders reported that the physician work has not changed. The committees felt that the existing value, significantly lower than the survey results, should be

maintained. Also, this would avoid creation of rank-order anomalies within the family of spirometric pulmonary function tests.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 19% No 81%

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) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
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CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time 0%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time** 0%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95144 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **0.12**
RUC RVU: **0.06**

CPT Descriptor: Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 12-year old male is seen on referral by his primary care physician for symptoms of progressively more severe rhinorrhea, sneezing, wheezing and coughing. Allergy tests showed positive reactions to cat and dog danders, six different genera of mold spores and dust mites. A decision is made to start allergen immunotherapy. The physician orders preparation of immunotherapy identifying the specific amount of each antigen, establishes the dosage schedule, and supervises the preparation of the vials. Because the patient will be receiving his immunotherapy injections at an outside clinic, single dose vials are ordered to ensure accuracy of dosing.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: None

Description of Intra-Service Work:

1. Physician determines which antigens are to be used for immunotherapy and at what concentrations.

2. Physician determines dosage schedule.

3. Physician provides direct supervision for sterile preparation of vials and needed quality control of the product through testing or other means.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005					
Presenter(s):	Donald Aaronson, MD, JCAAI; Gary Gross, MD, JCAAI; and Paul Fass, MD, AAOA					
Specialty(s):	Joint Council of Allergy, Asthma, and Immunology (JCAAI) and American Academy of Otolargyngic Allergy (AAOA)					
CPT Code:	95144					
Sample Size:	164	**Resp n:** 25		**Response:** 15.24 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.04	0.06	**0.06**	0.30	2.00
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		0.00	0.00	**3.00**	2.00	30.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95148	000	0.06

CPT Descriptor Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
11056	000	0.61

CPT Descriptor 1 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); two to four lesions

MPC CPT Code 2	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 2 Radiologic examination, knee; one or two views

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 11 **% of respondents:** 44.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 95144	**Key Reference CPT Code: 95148**
Median Pre-Service Time	0.00	
Median Intra-Service Time	3.00	2.00
Median Immediate Post-service Time	0.00	
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**3.00**	
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.96	2.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.26	2.95
Urgency of medical decision making	2.61	2.36

Technical Skill/Physical Effort (Mean)

Technical skill required	3.39	3.23
Physical effort required	2.26	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.52	3.14
Outcome depends on the skill and judgment of physician	3.57	3.27
Estimated risk of malpractice suit with poor outcome	3.96	3.68

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	2.86
Intra-Service intensity/complexity	2.52	2.55
Post-Service intensity/complexity	2.57	2.41

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code describes preparation of a single dose vial. This is a very low volume code, compared with 95165 which describes preparation of a multi-dose vial. The service is usually but not always reserved for situations where the immunotherapy injections are going to be provided by another health care practitioner. The reason for using a single dose vial as opposed to extracting the required dose from a multidose vial is to assure precision in the dosage provided. Very few allergists in the survey (9 in all) reported that they actually provided this service during the last year and of those, only 4 performed it any signficant number of times. Total responses for 95144 were 25 (although only 19

actually recommended an RVU). 21 of the responses – the vast majority - were from individuals that rarely or never provide the service. Of the 19 respondents who provided an RVU, 13 provided the same recommended work RVU for 95144 as for 95165 and 4 provided a slightly higher RVUs for 96165. Among the respondents who prepared a high volume of single dose vials every one of these individuals indicated the same recommended RVU for 95144 as for 95165. Respondents selected the same reference code – 95148 – for both codes.

Currently, 95165 and 95144 have the same work RVUs - 0.06 and the JCAAI/AAOA expert panel is in agreement that the work is identical for the two codes. The median survey work RVU for 95144 is 0.06 and the median total time is 3.2 minutes. The median time for 95165 is also 3.2 minutes; however, the median RVU is .12.

Based on the information above, we believe the survey results for 95144 are not valid. The sample size of individuals who actually perform the service was very small and many individuals who answered the survey have no experience with the service. We believe the survey results for 95165 are much more reliable than those for 95144. Moreover, clinical reality requires that the two codes have the same work RVU since the service from the perspective of the physician is exactly the same. The only difference is that the mixture of antigens are placed in one multidose vial in the case of Code 95165 and in a number of single dose vials in the case of Code 95144. The only real difference between the two services is in the practice expense since there are higher supply costs for vials and labels for 95144. Consequently, we are recommending that the survey results for 95165 be used in establishing the values for 95144 and that the survey results for 95144 be discarded. Therefore, we recommend work RVUs for 95144 of .12 – the same as what we are recommending for 95165.

Survey Data Summary

Approximately 49% of respondents selected 95148 as the key reference service code. The key reference service code has a 0.06 work RVU and has 2 minutes of total Harvard time. The mean value for the intensity/complexity measures was higher for the surveyed code for all of the measures except the Mental Effort and Judgment "urgency of medical decision making" measure.

MPC Comparison

It is difficult to find services on the MPC list that have RVUs of the level requested for this code. If, however, we view the service as preparing the complete multi dose vial, a total of 0.60 RVUs are being requested for 16 minutes of time (3.2 minutes X 5 doses). This compares with 0.17 work RVUs for 3 minutes of total time for interpreting a knee X-ray (Code 73560) and 0.61 work RVUs for 15 minutes of total come for paring a corn (Code 11056). In the case of each of these services, the requested work RVU is lower per minute of time than either of these two MPC services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 33% No 67%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 0%
B. Patients requiring this service are now:
   more complex (more work) 33% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 0%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95165 Global Period: 000

Recommended Work Relative Value
Specialty Society RVU: **0.12**
RUC RVU: **0.06**

CPT Descriptor: Professional services for the supervision of preparation and provision of antigens for allergy immunotherapy; single or multiple antigens (specify number of doses)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 12-year old male is seen by an allergy consultant for symptoms of progressively more severe rhinorrhea, sneezing, wheezing, coughing and dyspnea. Allergy tests showed significantly positive reactions to cat and dog danders, six different genera of mold spores and to dust mites. A decision is made to start allergen immunotherapy. The physician orders preparation of immunotherapy to be made in a multi-dose vial, identifying the amount of each antigen, establishes the dosage schedule, and supervises the preparation of antigens.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: None

Description of Intra-Service Work:

1. Physician determines which antigens are to be used for immunotherapy and at what concentrations.

2. Physician determines dosage schedule.

3. Physician provides direct supervision for sterile preparation of vials and needed quality control of the product through testing or other means.

Description of Post-Service Work: None

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005					
Presenter(s):	Donald Aaronson, MD, JCAAI; Gary Gross, MD, JCAAI; and Paul Fass, MD, AAOA					
Specialty(s):	Joint Council of Allergy, Asthma, and Immunology (JCAAI) and American Academy of Otolargyngic Allergy (AAOA)					
CPT Code:	95165					
Sample Size:	164	**Resp n:** 45		**Response:** 0.00 %		
Sample Type:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.04	0.06	**0.12**	0.35	2.00	
Pre-Service Evaluation Time:			**0.0**			
Pre-Service Positioning Time:			**0.0**			
Pre-Service Scrub, Dress, Wait Time:			**0.0**			
Intra-Service Time:	0.00	0.00	**3.00**	2.00	30.00	

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**0.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15), 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95148	000	0.06

CPT Descriptor Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); four single stinging insect venoms

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 1 Radiologic examination, knee; one or two views

MPC CPT Code 2	Global	Work RVU
11056	000	0.61

CPT Descriptor 2 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); two to four lesions

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 22 **% of respondents:** 48.8 %

TIME ESTIMATES (Median)

	CPT Code: 95165	Key Reference CPT Code: 95148
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	3.00	2.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**3.00**	
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.35	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.00
Urgency of medical decision making	2.93	2.95

Technical Skill/Physical Effort (Mean)

Technical skill required	3.55	3.21
Physical effort required	2.18	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.85	3.61
Outcome depends on the skill and judgment of physician	3.90	3.55
Estimated risk of malpractice suit with poor outcome	3.98	3.84

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.50	2.97
Intra-Service intensity/complexity	2.65	2.39
Post-Service intensity/complexity	2.76	2.54

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

This code was assigned physician work in the Harvard study and has had a work RVU since the RBRVS was implemented in 1992. CMS included this code in this Five-Year Review; neither JCAAI nor AAOA requested its inclusion. JCAAI and AAOA decided to survey this code and present recommendations to the RUC.

Survey Data Summary

This code is reimbursed on a "per dose" basis. However, as with the allergy testing codes, physicians do not typically prepare a single dose – in fact the code descriptor is for that of a "multi-dose vial." Therefore, it was decided, with the approval of the RUC Workgroup, that we would obtain data on the time associated with preparation of the typical number of doses prepared at a time, and have survey respondents calculate from that number, the time required to prepare a single dose. Respondents were instructed to use the CMS definition of dose which is one cc even if they used a different measure of dose for treatment purposes. This was necessary in order to have the survey yield results that could be compared to existing work RVU.

The median response to the survey question asking the number of ccs prepared in a typical multi-dose vial was 5 ccs with total time for a single dose of 3.2 minutes, which is up from the 2 minutes of Harvard total time assigned to this code, as noted in the RUC Database. Since it is standard practice for allergists to prepare 10 treatment doses in a multi-dose vial at time, it is inferred from this response that the typical treatment dose being used by most allergists was 0.5 ccs.

As noted in our cover letter, the RUC survey for 000 global services is designed for minor surgical procedures and does not really "fit" this service since it is generally done outside of the patient's presence. Feedback we have received from survey respondents indicated that the definitions of pre, intra and post time on the survey form were very difficult to apply to this particular service. We think physicians had a hard time distinguishing between pre, intra and post time and believe it would be appropriate to view the 3.2 minutes all as intra time.

Approximately 49% of respondents selected 95148 as the key reference service code. The key reference service code has a 0.06 work RVU and has 2 minutes of total Harvard time. The mean value for the intensity/complexity measures was higher for the surveyed code for all of the measures except the Mental Effort and Judgment "urgency of medical decision making" measure.

The median survey response work RVU recommendation is 0.12. Based on this, the joint JCAAI/AAOA expert panel recommends an increase in the work RVU to 0.12. This equates to 0.60 RVUs for the typical 5 cc multi-dose vial. This code has never been valued by the RUC - the current values are based on Harvard data which, we believe, undervalued the work for this code. The survey results corroborate this. While we realize that this would cause this code to be valued substantially more than the reference code, we note that the values for the reference codes have also never been reviewed by the RUC and are likely undervalued for the same reason that the surveyed code is.

MPC Comparison

It is difficult to find services on the MPC list that have RVUs of the level requested for this code. If, however, we view the service as preparing the complete multi dose vial, a total of 0.60 RVUs are being requested for 16 minutes of time (3.2 minutes X 5 doses). This compares with 0.17 work RVUs for 3 minutes of total time for interpreting a knee X-ray (Code 73560) and 0.61 work RVUs for 15 minutes of total come for paring a corn (Code 11056). In the case of each of these services, the requested work RVU is lower per minute of time than either of these two MPC services.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions:

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 38% No 62%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 0%
B. Patients requiring this service are now:
   more complex (more work) 35% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 0% no change 0%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95816 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.08**
RUC RVU: **1.08**

CPT Descriptor: Electroencephalogram (EEG); including recording awake and drowsy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female has developed memory complaints and word finding difficulty which fluctuates markedly from day to day. Examination is notable for occasional paraphasic errors and poor short-term memory recall. Head CT scan is normal. An EEG is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Determine which type of EEG study is most appropriate for the patient based on the referral question being asked.

Description of Intra-Service Work: Supervise patient preparation and performance of the test by the technician. Review the recorded data, assess the normal and abnormal findings, review the activation procedures performed including hyperventilation and photic stimulation, interpret the data, and provide clinical correlation of the findings based on the patient's history.

Description of Post-Service Work: Generate the report and make recommendations for further management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Gregory L. Barkley, MD Susan Herman, MD Marc Raphaelson, MD					
Specialty(s):	American Academy of Neurology American Clinical Neurophysiology Society					
CPT Code:	95816					
Sample Size:	84	**Resp n:** 32		**Response:** 38.0 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.80	1.30	**1.50**	1.68	4.85
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	10.00	**15.00**	25.00	90.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				

Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95813	XXX	1.73

CPT Descriptor Electroencephalogram (EEG) extended monitoring; greater than one hour

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
70450	XXX	0.85

CPT Descriptor 1 Computed tomography, head or brain; without contrast material

MPC CPT Code 2	Global	Work RVU
70496	XXX	1.75

CPT Descriptor 2 Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

Other Reference CPT Code	Global	Work RVU
95806	XXX	1.66

CPT Descriptor Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 62.5 %

TIME ESTIMATES (Median)	CPT Code: 95816	Key Reference CPT Code: 95813
Median Pre-Service Time	5.00	15.00
Median Intra-Service Time	15.00	30.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**30.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.45	3.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.70	3.90
Urgency of medical decision making	3.50	3.75

Technical Skill/Physical Effort (Mean)

Technical skill required	4 10	4.35
Physical effort required	2.15	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.70
Outcome depends on the skill and judgment of physician	4.35	4.55
Estimated risk of malpractice suit with poor outcome	3.10	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.15	2.50
Intra-Service intensity/complexity	3.70	4.05
Post-Service intensity/complexity	3.05	3.37

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The reference service code chosen by the survey participants, 95813, is not a valid comparison for 95816 because the physician work involved in providing the reference service has increased substantially since it was last surveyed in 1995. In 1995, the reference service did not include video assist or other software, only half the channels existed and the physician could not change montages. The changes in the technology since 1995 have made 95813 a more intense and complex service. The current value of 95813 is based on the service as it was performed in 1995. We believe that the survey participants were comparing 95816 to 95813 at the level of complexity and intensity it is being performed at

today, not as it is valued (i.e., based on the service provided in 1995). Therefore, 95813 cannot be used as a direct comparison for physician work to 95816 and it is more appropriate to determine the physician work through an IWPUT analysis.

The median survey data time for 95816 (5 minutes pre-service, 15 minutes intra-service, and 10 minutes post-service) with the currently assigned RVW of 1.08 results in an IWPUT of .049 which is consistent with the IWPUT of other comparable services from the MPC list with similar intra-service times. For example, 70545 (MR angiography, head; with contrast material(s)) has an intra-service time of 15 minutes and an IWPUT of .057. Code 70496 (CT angiography, head) has an IWPUT of .067 and 71275 (CT angiography, chest) has an IWPUT of .049. Many radiology procedures that neurologists also perform are comparable in physician work and intensity have IWPUTs in the range of .04 to .06. In addition, polysomnography code 95810, a service also performed by neurologists, has an IWPUT of .045. For these reasons we believe that an RVW of 1.08 with the median service times from the survey data for code 95816 are appropriate.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 50% No 50%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 6% I do not agree 94%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 25% from inpatient to outpatient 6% no change 69%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: _____

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:				
Physician Intra-Service Time:				
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time	**Change: In Time**
Complete if the global period is 010, or 090				
Discharge Day (none, ½, or full)		**99238:**		
Number and Level of Office Visits:		**99211:**		
		99212:		
		99213:		
		99214:		
		99215:		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95819 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.29**
RUC RVU: **1.08**

CPT Descriptor: Electroencephalogram (EEG); including recording awake and asleep

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old male has complaints of recurrent episodes of a strange epigastric rising feeling followed by a strange taste in his mouth and then a sense of unreality where he is not fully able to interact with others around him. The episode lasts one minute and leaves him feeling tired afterward. An EEG is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 9%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Determine which type of EEG study is most appropriate for the patient based on the referral question being asked.

Description of Intra-Service Work: Supervise patient preparation and performance of the test by the technician. Review the recorded data, assess the normal and abnormal findings, review the activation procedures performed including hyperventilation and photic stimulation, interpret the data, and provide clinical correlation of the findings based on the patient's history.

Description of Post-Service Work: Generate the report and make recommendations for further management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Gregory L. Barkley, MD Susan Herman, MD Marc Raphaelson, MD					
Specialty(s):	American Academy of Neurology American Clinical Neurophysiology Society					
CPT Code:	95819					
Sample Size:	84	**Resp n:** 32		**Response:** 38.0 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.80	1.29	**1.58**	1.73	4.90
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		5.00	15.00	**15.00**	29.00	120.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				

Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95813	XXX	1.73

CPT Descriptor Electroencephalogram (EEG) extended monitoring; greater than one hour

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
70450	XXX	0.85

CPT Descriptor 1 Computed tomography, head or brain; without contrast material

MPC CPT Code 2	Global	Work RVU
70496	XXX	1.75

CPT Descriptor 2 Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

Other Reference CPT Code	Global	Work RVU
95922	XXX	0.96

CPT Descriptor Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and R-R interval changes during Valsalva maneuver and at least five minutes of passive tilt

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 65.6 %

TIME ESTIMATES (Median)	**CPT Code: 95819**	**Key Reference CPT Code: 95813**
Median Pre-Service Time	5.00	15.00
Median Intra-Service Time	15.00	30.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**30.00**	**60.00**
ther time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.48	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	4.00
Urgency of medical decision making	3.71	3.81

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	4.43
Physical effort required	2.24	2.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.62	3.76
Outcome depends on the skill and judgment of physician	4.33	4.48
Estimated risk of malpractice suit with poor outcome	3.19	3.38

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2 29	2.48
Intra-Service intensity/complexity	3.95	4.05
Post-Service intensity/complexity	3.10	3.29

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The reference service code chosen by the survey participants, 95813, is not a valid comparison for 95819 because the physician work involved in providing the reference service has increased substantially since it was last surveyed in 1995. In 1995, the reference service did not include video assist or other software, only half the channels existed and the physician could not change montages. The changes in the technology since 1995 have made 95813 a more intense and complex service. The current value of 95813 is based on the service as it was performed in 1995. We believe that the survey participants were comparing 95819 to 95813 at the level of complexity and intensity it is being performed at

today, not as it is valued (i.e., based on the service provided in 1995). Therefore, 95813 cannot be used as a direct comparison for physician work to 95819 and it is more appropriate to determine the physician work through an IWPUT analysis.

The survey data show that 95819 involves 5 additional minutes of physician intra-service work time as compared to 95816. Using the 25th percentile RVW of 1.29 and the median survey data time for 95819 (5 minutes pre-service, 20 minutes intra-service, 10 minutes post-service), the resulting IWPUT is .047 which is consistent with the IWPUT of other comparable services from the MPC list with similar intra-service times. For example, codes 73721 (MRI joint of lower extremity, without dye) and 70496 (CT angiography, head) have intra-service times of 20 minutes and IWPUTs of .067. In addition, polysomnography code 95810 has an IWPUT of .045. For these reasons, we believe that an RVW of 1.29 with the median service times from the survey data for code 95819 are appropriate.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 53% No 47%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 6% I do not agree 94%
B. Patients requiring this service are now:
   more complex (more work) 94% less complex (less work) 0% no change 6%
C. The usual site-of-service has changed:
   from outpatient to inpatient 18% from inpatient to outpatient 6% no change 76%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: _____

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95861 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.68**
RUC RVU: **1.54**

CPT Descriptor: Needle electromyography; two extremities with or without related paraspinal areas

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75 year old woman with a five month history of marked pain and proximal left lower limb weakness now presents with 3 weeks of severe pain and weakness in the proximal right lower limb. Physical examination shows a cachectic elderly woman with disproportionate wasting of the left more than right thigh muscles. Needle electromyography of 2 limbs is indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the EMG. Specifically the physician considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studies are then determined

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. The physician places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode in to each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle several voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed.

Description of Post-Service Work: Post-service work involves grading of the insertional, spontaneous, and voluntary motor unit potential activity from each muscle examined, summarization of clinical and electrodiagnostic data, physician interpretation.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Benn Smith, MD; Andrea Boon, MD; Jim Anthony, MD; Marc Raphaelson, MD; Robert Goldberg, DO					
Specialty(s):	American Association of Neuromuscular & Electrodiagnostic Medicine American Academy of Neurology American Academy of Physical Medicine and Rehabilitation					
CPT Code:	95861					
Sample Size:	106	**Resp n:** 51		**Response:** 48.11 %		
Sample Type:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	

		CPT Code:				
Survey RVW:		0.90	1.44	**1.68**	1.88	3.00
Pre-Service Evaluation Time:				**15.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	20.00	**25.00**	30.00	45.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23), 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95860	XXX	0.96

CPT Descriptor Needle electromyography; one extremity with or without related paraspinal areas

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 43 **% of respondents:** 84.3 %

TIME ESTIMATES (Median)

	CPT Code: 95861	Key Reference CPT Code: 95860
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	25.00	34.00
Median Immediate Post-service Time	10.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**50.00**	**34.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.14	3.74
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.60
Urgency of medical decision making	3.53	3.26

Technical Skill/Physical Effort (Mean)

Technical skill required	4.35	3.98
Physical effort required	3.70	3.28

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.14	2.88
Outcome depends on the skill and judgment of physician	4.42	4.21
Estimated risk of malpractice suit with poor outcome	3.00	2.86

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.72	3.40
Intra-Service intensity/complexity	4.37	3.63
Post-Service intensity/complexity	3.79	3.42

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The specialty societies held a conference call with the RUC advisors from the different specialties after compiling the survey data. The survey was provided to physicians across the United States in different practice settings. CPT code 95861 had not been surveyed in the past therefore the current RVU is from Harvard data. Additionally, the code did not have a vignette. The societies surveying the code believe that the previous valuation for the code was incorrect because of a flawed mechanism. The code did not have vignette and therefore could not be appropriately valued. Therefore,

with appropriate vignettes and surveys now complete, the societies believe there is compelling evidence to appropriatly value the code as the surveys demonstrate.

The specialty societies are requesting the median RVU as demonstrated by the survey process. The current RVU as provided by Harvard is an RVU of 1.54. The specialty societies are requesting an RVU of 1.68.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. See attached

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 27% No 73%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 7% I do not agree 93%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) 0% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 21% no change 79%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:95872 Global Period: XXX Specialty Society RVU: **3.00**

RUC RVU: **3.00**

CPT Descriptor: Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, and/all sites of each muscle studied

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 69 year old man presents with two months of intermittent then constant double vision and ptosis. Physical examination is otherwise normal. Laboratory investigations suggest normal thyroid function, glucose metabolism, and acetylcholine receptor binding antibodies. Nerve conduction studies, including 2 Hz repetitive stimulation of distal upper limb, proximal upper limb, and facial motor nerves at rest and after isometric exercise are normal. Routine EMG of upper limb and facial muscles is normal. Single fiber needle electromyography is indicated

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the study. Specifically the physician must consider the potential clinical problem that SFEMG would help characterize and choose the appropriate proximal and distal muscles or study considering the problem and the available normals for the muscles to be studied.

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure and possible complications including bleeding and bruising. The physician places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. The pre-examination includes determination of surface anatomic landmarks, and identification of structures to avoid during the needle insertion. Once the single fiber needle electrode has been inserted into the muscle, the electrical activity with minimal activation is recorded on the EMG machine; this often requires changing the limb position and encouraging the patient to maintain a steady low level of contraction of the muscle being examined. The physician encourages the patient to maintain steady, low level muscle contraction. The large data file is stored on the EMG machine to be analyzed either with the patient in the room or after the patient leaves. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where bleeding may be observed.

Description of Post-Service Work: Post-service work involves the process of sitting at the EMG machine and manipulating various cursors along the (1000-2000) potentials being individually analyzed, omitting spurious potentials, and insuring that the data are reliable. Additional work involves summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and sometimes suggestions for further investigations.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005
Presenter(s):	Benn Smith, MD; Andrea Boon, MD; Jim Anthony, MD; Robert Goldberg, DO, Marc Raphelson, MD
Specialty(s):	American Association of Neuromuscular & Electrodiagnostic Medicine American Academy of Neurology American Academy of Physical Medicine & Rehabilitation

CPT Code:	95872		
Sample Size:	36	Resp n: 31	Response: 86.11 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.96	1.55	**2.00**	3.00	4 50
Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	45.00	**60.00**	60.00	120.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	20.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95860	XXX	0.96

CPT Descriptor Needle electromyography, one extremity with or without related paraspinals.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 80.6 %

TIME ESTIMATES (Median)	**CPT Code: 95872**	**Key Reference CPT Code: 95860**
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	60.00	34.00
Median Immediate Post-service Time	20.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**95.00**	**34.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.72	3.68
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.28
Urgency of medical decision making	3.84	3.04

Technical Skill/Physical Effort (Mean)

Technical skill required	4.84	3.64
Physical effort required	4.48	3.36

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.92	2.56
Outcome depends on the skill and judgment of physician	4.80	4.00
Estimated risk of malpractice suit with poor outcome	3.16	2.76

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.76	3.12
Intra-Service intensity/complexity	4.84	3.36
Post-Service intensity/complexity	4.12	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The specialty societies held a conference call with the RUC advisors from the different specialties after compiling the survey data. The survey was provided to physicians across the United States in different practice settings. CPT code 95872 had not been surveyed in the past therefore the current RVU is from Harvard data. Additionally, the code did not have a vignette. The societies surveying the code believe that the previous valuation for the code was incorrect because of a flawed mechanism and because of a anomalous relationship between code 95872 and the other codes in the family.

The code did not originally have a vignette and could not be appropriately valued. Therefore, with appropriate vignettes and surveys now complete, the societies believe there is compelling evidence to value the code at the 75th percentile. The procedure is very time consuming and complex. Only a few of the top physicians around the nation perform the procedure because of the complex nature of the study. Less than a 1000 studies have been performed every year since 2003.

Additionally, this procedure is currently given an RVU of 1.50 which is less than a 2-limb needle electromyography. The complexity of the procedure and time involved should allow the physician to have a greater work RVU. This procedure is similar in complexity to deep brain stimulation (CPT code 95978) that provides an RVU of 3.50 with a total RUC time of 70 minutes. The total RUC time provided by the survey is 95 minutes. Therefore, the specialties request an RVU of 3.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 26% No 74%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 13% I do not agree 87%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 3% no change 100%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:95900 Global Period: XXX Specialty Society RVU: **0.55**

RUC RVU: **0.42**

CPT Descriptor: Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female presents to the clinic with weakness of the right quadriceps muscle and pain over the right hip. These symptoms began following a motor vehicle accident where she was pinned by the steering wheel for several minutes. A traumatic femoral neuropathy is suspected. A motor nerve conduction study without f-wave of the right femoral nerve is indicated

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the nerve conduction study, Specifically the physician considers available recording and stimulating sites for the nerve, and determining the appropriate sites based on the possible sites of nerve injury. The appropriate muscles to be studies are then determined.

Description of Intra-Service Work: Intra-service work includes physician performance or supervision of patient preparation, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and recording of the waveform of the resulting compound muscle action potentials. The waveform is analyzed with respect to latency, amplitude and configuration. Interelectrode distances are measured and recorded. 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 nerve conduction velocities, 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

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Benn Smith, MD; Andrea Boon, MD; Jim Anthony, MD;Marc Raphaelson, MD; Robert Goldberg, DO					
Specialty(s):	American Association of Neuromuscular & Electrodiagnostic Medicine American Academy of Neurology American Academy of Physical Medicine and Rehabilitation					
CPT Code:	95900					
Sample Size:	105	**Resp n:** 49		**Response:** 46.66 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
urvey RVW:		0.50	0.55	**0.55**	0.60	0.96
Pre-Service Evaluation Time:				**4.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		

CPT Code:

Intra-Service Time:		2.00	5.00	**6.00**	10.00	35.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**4.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**				
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**				
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**				
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**				

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95903	XXX	0.60

CPT Descriptor Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 35 **% of respondents:** 71.4 %

TIME ESTIMATES (Median)

	CPT Code: 95900	**Key Reference CPT Code: 95903**
Median Pre-Service Time	4.00	8.00
Median Intra-Service Time	6.00	10.00
Median Immediate Post-service Time	4.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**14.00**	**28.00**
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.54	3.57
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.34	3.43
Urgency of medical decision making	3.09	3.06

Technical Skill/Physical Effort (Mean)

Technical skill required	3.69	3.74
Physical effort required	2.94	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.20	2.09
Outcome depends on the skill and judgment of physician	4.03	3.97
Estimated risk of malpractice suit with poor outcome	2.46	2.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.31	3.31
Intra-Service intensity/complexity	3.17	3.54
Post-Service intensity/complexity	3.31	3.31

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The specialty societies held a conference call with the RUC advisors from the different specialties after compiling the survey data. The survey was provided to physicians across the United States in different practice settings. CPT code 95900 had not been surveyed in the past therefore the current RVU is from Harvard data. The societies surveying the code believe that the previous valuation for the code was incorrect because of a flawed mechanism. The flawed mechanism was that a survey has not been done on these codes. Therefore, with appropriate surveys now complete, the societies believe there is compelling evidence to appropriatly value the code as the surveys demonstrate.

Interestingly enough, both the median and the 25th percentile show that the code should be reimbursed with an RVU of 0.55. The survey evidence is compelling that the appropriate reimbursement for this code be 0.55.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Please see attached.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 20% No 80%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 9% I do not agree 91%
B. Patients requiring this service are now:
   more complex (more work) 73% less complex (less work) 0% no change 27%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 36% no change 64%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:95904 Global Period: XXX Specialty Society RVU: **0.55**

RUC RVU: **0.34**

CPT Descriptor: Nerve conduction, amplitude and latency/velocity study, each nerve; sensory

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year woman with no significant past medical history presents with three months of tingling asleep numbness in both lower limbs distally and in the left more than right hand. Physical examination shows normal strength, loss of pin prick and vibration over the feet, lower legs, and fingers bilaterally, as well as absent ankle reflexes. Differential diagnostic considerations include sensorimotor peripheral neuropathy, sensory peripheral neuropathy, sensory neuronopathy, and central nervous system disorders. Nerve conduction studies show normal distal lower and upper limb motor nerve conduction values. Sensory nerve conduction studies are indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 2%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the nerve conduction study. Specifically the physician considers available recording and stimulating sites for the nerve, and determining the appropriate sites based on the possible sites of nerve injury. The appropriate muscles to be studies are then determined.

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. After identifying anatomic landmarks, the physician (and/or the technologist) cleans the skin overlying anticipated nerve stimulation and recording sites and places the recording electrodes and ground surface electrodes. Electrical stimuli are delivered via the surface stimulating electrode prongs; this includes searching for the optimal site by the obtained response, rotating the prongs to secure the proper shape of waveform on the EMG machine screen, and constantly communicating with the patient in an effort to reduce muscle artifact. Reporting procedures are explained to the patient.

Description of Post-Service Work: Post-service work involves assessing the waveforms from each sensory nerve tested, summarization of clinical and electrodiagnostic data, writing the physician interpretation, generation of a differential diagnosis, and sometimes providing suggestions for further investigations.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Benn Smith, MD; Andrea Boon, MD; Jim Anthony, MD; Marc Raphaelson, MD; Robert Goldberg, DO					
Specialty(s):	American Association of Neuromuscular & Electrodiagnostic Medicine					
CPT Code:	95904					
Sample Size:	105	**Resp n:** 47		**Response:** 44.76 %		
Sample Type:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.45	0.50	**0.55**	0.60	0.96	

CPT Code:

Pre-Service Evaluation Time:			**4.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	2.00	5.00	**5.00**	10.00	35.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**3.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95903	XXX	0.60

CPT Descriptor nerve conduction, amplitude, and latency/velocity study, each nerve; motor, with F-wave study

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 25 **% of respondents:** 53.1 %

TIME ESTIMATES (Median)	**CPT Code: 95904**	**Key Reference CPT Code: 95903**
Median Pre-Service Time	4.00	8.00
Median Intra-Service Time	5.00	10.00
Median Immediate Post-service Time	3.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**12.00**	**28.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.60	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.48	3.44
Urgency of medical decision making	3.16	3.16

Technical Skill/Physical Effort (Mean)

Technical skill required	3.84	3.80
Physical effort required	2.96	3.08

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.28	2.28
Outcome depends on the skill and judgment of physician	4.04	3.96
Estimated risk of malpractice suit with poor outcome	2.68	2.72

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.40	3.36
Intra-Service intensity/complexity	3.36	3.56
Post-Service intensity/complexity	3.28	3.28

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The specialty societies held a conference call with the RUC advisors from the different specialties after compiling the survey data. The survey was provided to physicians across the United States in different practice settings. CPT code 95904 had not been surveyed in the past therefore the current RVU is from Harvard data. Additionally, the code did not have a vignette. The societies surveying the code believe that the previous valuation for the code was incorrect because of a flawed mechanism. The code did not have vignette and therefore could not be appropriately valued. Therefore,

with appropriate vignettes and surveys now complete, the societies believe there is compelling evidence to appropriatly value the code as the surveys demonstrate.

The specialty societies are requesting the median RVU as demonstrated by the survey process which is an RVU of 0.55. This is a similar procedure to CPT code 95900 and therefore the codes should have similar RVUs. CPT code 95903 is more work and therefore deserves a higher RVU.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. Please see attached

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 26% No 74%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 83% less complex (less work) 0% no change 17%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 33% no change 67%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code:

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95925 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.79**
RUC RVU: **0.54**

CPT Descriptor: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 35-year-old woman complains of numbness in the right arm. Physical examination, MRI of the brain, needle EMG and nerve conduction studies are normal. Median somatosensory evoked potentials are indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 19%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the SEP Specifically the physician considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studies are then determined.

Description of Intra-Service Work: Intra-service work includes physician supervision of patient preparation, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and/or dermatomes and recording the esulting evoked potentials at several sites from periphery to cerebral cortex. Multiple trials are averaged since the signals are very small. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work: Post-service work involves determination of the latency and amplitude of the evoked potentials, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and suggestions for further work-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Benn Smith, MD; Andrea Boon, MD; Jim Anthony, MD; Robert Goldberg, DO; Susan Herman, MD; Gregory L. Barkley, MD; Marc Raphaelson, MD					
Specialty(s):	American Association of Neuromuscular and Electrodiagnostic Medicine American Academy of Neurology American Academy of Physical Medicine and Rehabilitation American Clinical Neurophysiology Society					
CPT Code:	95925					
Sample Size:	38	**Resp n:** 36		**Response:** 94.7 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.45	0.79	**1.05**	1.50	4.00
re-Service Evaluation Time:				**6.5**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		0.00	8.75	**15.00**	30.00	240.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95928	XXX	1.50

CPT Descriptor Central motor evoked potential study (transcranial motor stimulation); upper limbs

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95903	XXX	0.60

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

MPC CPT Code 2	Global	Work RVU
70450	XXX	.85

CPT Descriptor 2 Computed tomography, head or brain; without contrast material

Other Reference CPT Code	Global	Work RVU
95860	XXX	0.96

CPT Descriptor Needle electromyography; one extremity with or without related paraspinal areas

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 47.2 %

TIME ESTIMATES (Median)

	CPT Code: 95925	**Key Reference CPT Code: 95928**
Median Pre-Service Time	6.50	15.00
Median Intra-Service Time	15.00	60.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**31.50**	**90.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.76	3.88
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.82
Urgency of medical decision making	3.12	3.35

Technical Skill/Physical Effort (Mean)

Technical skill required	4.12	4.24
Physical effort required	3.00	3.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.65	3.59
Outcome depends on the skill and judgment of physician	3.94	4.06
Estimated risk of malpractice suit with poor outcome	3.12	3.47

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.18	3.41
Intra-Service intensity/complexity	3.47	3.76
Post-Service intensity/complexity	3.53	3.53

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The reference code most commonly selected by the survey participants, 95928, is not a valid comparison for 95925. Code 95928 (Central motor evoked potential study (transcranial motor stimulation); upper limbs) requires constant physician attendance with the patient and the physician must perform the stimulation and recording, which is not the case for 95925.

A more appropriate comparison regarding physician time and work is to code 95903 (Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study), which was the second most commonly selected reference service code by the survey participants for 95925. Code 95903 has 10 minutes of intra-service time, an RVW of 0.60 and an IWPUT of 0.020. Another comparable procedure is 95860 (Needle electromyography; one extremity with or without related paraspinal areas) which has an IWPUT of 0.028.

By using the 25th percentile RVW for 95925 (0.79 RVUs) and the median intra-service time of 15 minutes, the resulting IWPUT is 0.028 which is in the 0.020 - 0.028 range. For these reasons, we believe that an RVW of .79 with the median service times from the survey data for code 95925 are appropriate.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 31% No 69%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 9% I do not agree 91%
B. Patients requiring this service are now:
   more complex (more work) 91% less complex (less work) 0% no change 9%
C. The usual site-of-service has changed:
   from outpatient to inpatient 27% from inpatient to outpatient 9% no change 64%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: _____

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95926 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.79**
RUC RVU: **0.54**

CPT Descriptor: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Over the last two months, a 45-year-old man has noted progressive difficulty in gait, urinary urgency and numbness in his feet. Physical examination is remarkable for diffuse mild (4/5) weakness in the lower limbs (right side worse), hyperactive knee and ankle muscle stretch reflexes with a right Babinski sign and equivocal loss of vibration sense in the feet. The referral diagnoses include cervical spondylosis, motor neuron disease or intracranial pathology (e.g. hydrocephalus or stroke). Bilateral tibial nerve somatosensory evoked potentials are indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 22%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the SEP. Specifically the physician considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studies are then determined.

Description of Intra-Service Work: Intra-service work includes: physician supervision of patient preparation; placement of ground, stimulating and recording surface electrodes; stimulation of nerves and/or dermatomes, and recording the resulting evoked potentials at several sites from periphery to cerebral cortex. Multiple trials are averaged since the signals are very small. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work: Post-service work involves determination of the latency and amplitude of the evoked potentials, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and suggestions for further work-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Benn Smith, MD; Andrea Boon, MD; Jim Anthony, MD; Robert Goldberg, DO; Susan Herman, MD; Gregory L. Barkley, MD; Marc Raphaelson, MD					
Specialty(s):	American Association of Neuromuscular and Electrodiagnostic Medicine American Academy of Neurology American Academy of Physical Medicine and Rehabilitation American Clinical Neurophysiology Society					
CPT Code:	95926					
Sample Size:	38	**Resp n:** 36		**Response:** 94.7 %		
ample Type:	Panel					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Survey RVW:	0.45	0.79	**1.03**	1.50	4.00	
Pre-Service Evaluation Time:			**6.5**			

Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	0.00	8.75	**15.00**	31.25	240.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95928	XXX	1.50

CPT Descriptor Central motor evoked potential study (transcranial motor stimulation); upper limbs

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95903	XXX	0.60

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

MPC CPT Code 2	Global	Work RVU
70450	XXX	0.85

CPT Descriptor 2 Computed tomography, head or brain; without contrast material

Other Reference CPT Code	Global	Work RVU
95903	XXX	0.60

CPT Descriptor Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 47.2 %

TIME ESTIMATES (Median)

	CPT Code: 95926	**Key Reference CPT Code: 95928**
Median Pre-Service Time	6.50	15.00
Median Intra-Service Time	15.00	60.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**31.50**	**90.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.71	3.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.82
Urgency of medical decision making	3.18	3.41

Technical Skill/Physical Effort (Mean)

Technical skill required	4.12	4.18
Physical effort required	3.00	3.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.71	3.65
Outcome depends on the skill and judgment of physician	3.88	4.00
Estimated risk of malpractice suit with poor outcome	3.06	3.47

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.24	3.35
Intra-Service intensity/complexity	3.59	3.82
Post-Service intensity/complexity	3.59	3.59

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The reference code most commonly selected by the survey participants, 95928, is not a valid comparison for 95926. Code 95928 (Central motor evoked potential study (transcranial motor stimulation); upper limbs) requires constant physician attendance with the patient and the physician must perform the stimulation and recording, which is not the case for 95926.

A more appropriate comparison regarding physician time and work is to code 95903 (Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study), which was the second most commonly selected reference service code by the survey participants for 95926. Code 95903 has 10 minutes of intra-service time, an RVW of 0.60 and an IWPUT of 0.020. Another comparable procedure is 95860 (Needle electromyography; one extremity with or without related paraspinal areas) which has an IWPUT of 0.028.

By using the 25th percentile RVW for 95926 (0.79 RVUs) and the median intra-service time of 15 minutes, the resulting IWPUT is 0.028 which is in the 0.020 - 0.028 range. For these reasons, we believe that an RVW of .79 with the median service times from the survey data for code 95926 are appropriate.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 31% No 69%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 9% I do not agree 91%
B. Patients requiring this service are now:
   more complex (more work) 73% less complex (less work) 9% no change 18%
C. The usual site-of-service has changed:
   from outpatient to inpatient 27% from inpatient to outpatient 9% no change 64%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: _____

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95927 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.00**
RUC RVU: **.54**

CPT Descriptor: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old man reports back pain in the thoracic and lumbar region. Imaging studies reveal disc herniations at the T6-7 and T10-11 regions, both impinging on the thecal sac. Dermatomal somatosensory evoked potentials are indicated.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 33%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination to establish the questions to be addressed as part of the SEP. Specifically the physician considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician. The appropriate muscles to be studies are then determined.

Description of Intra-Service Work: Intra-service work includes: physician supervision of patient preparation; placement of ground; stimulating and recording surface electrodes; stimulation of nerves and/or dermatomes and recording the resulting evoked potentials at several sites from periphery to cerebral cortex. Multiple trials are averaged since the signals are very small. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work: Post-service work involves determination of the latency and amplitude of the evoked potentials, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and suggestions for further work-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s).	Benn Smith, MD; Andrea Boon, MD; Jim Anthony, MD; Robert Goldberg, DO; Susan Herman, MD; Gregory L. Barkley, MD; Marc Raphaelson, MD					
Specialty(s):	American Association of Neuromuscular and Electrodiagnostic Medicine American Academy of Neurology American Academy of Physical Medicine and Rehabilitation American Clinical Neurophysiology Society					
CPT Code:	95927					
Sample Size:	38	**Resp n:** 15		**Response:** 39.4 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
urvey RVW:		0.60	0.73	**1.00**	1.23	1.80
Pre-Service Evaluation Time:				**6.5**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		

code95927

Intra-Service Time:		3.00	12.50	**15.00**	25.00	120.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**10.00**					
Critical Care time/visit(s):	**0.0**	99291x **0.0**	99292x **0.0**			
Other Hospital time/visit(s):	**0.0**	99231x **0.0**	99232x **0.0**	99233x **0.0**		
Discharge Day Mgmt:	**0.0**	99238x **0.00**	99239x **0.00**			
Office time/visit(s):	**0.0**	99211x **0.0**	12x **0.0**	13x **0.0**	14x **0.0**	15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95828	XXX	1.50

CPT Descriptor Central motor evoked potential study (transcranial motor stimulation); upper limbs

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95903	XXX	0.60

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

MPC CPT Code 2	Global	Work RVU
70496	XXX	1.75

CPT Descriptor 2 Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

Other Reference CPT Code	Global	Work RVU
95903	XXX	0.60

CPT Descriptor Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 40.0 %

TIME ESTIMATES (Median)

	CPT Code: 95927	**Key Reference CPT Code: 95828**
Median Pre-Service Time	6.50	15.00
Median Intra-Service Time	15.00	60.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**31.50**	**90.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.80	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	4.00
Urgency of medical decision making	2.80	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.40	4.60
Physical effort required	3.00	3.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.40	3.60
Outcome depends on the skill and judgment of physician	3.60	3.80
Estimated risk of malpractice suit with poor outcome	2.20	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.20	3.40
Intra-Service intensity/complexity	3.60	3.80
Post-Service intensity/complexity	3.00	3.40

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The reference code most commonly selected by the survey participants, 95928, is not a valid comparison for 95927. ode 95928 (Central motor evoked potential study (transcranial motor stimulation); upper limbs) requires constant physician attendance with the patient and the physician must perform the stimulation and recording, which is not the case for 95927.

A more appropriate comparison regarding physician time and work would have been to code 95903 (Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study), which was the second most commonly selected reference service by the survey participants for 95927. Code 95903 has 10 minutes of intra-service time, an RVW of 0.60 and an IWPUT of 0.020. Another comparable procedure is 95860 (Needle electromyography; one extremity with or without related paraspinal areas) which has an IWPUT of 0.028.

The IWPUT for 95927 based on the 25th percentile RVW (0.73) and intra-service time of 20 minutes is 0.014. This IWPUT is not in line with the IWPUT for 95925 and 95926 (0.028) and RVWs of 0.79, especially considering that code 95927 involves more work, 5 additional minutes of physician intra-service time, than the 95925 and 95926 services. While the physician stimulates only the upper or lower limbs for 95925 or 95926 the physician must stimulate any number of dermatomes in the trunk or head and spend additional time interpreting the wave forms and determining the normal range of stimulus from the affected area of the body to the brain in performing 95927.

To bring the IWPUT for 95927 in line with our recommendations for SEP codes 95925 and 95926, we recommend the adoption of the median RVW of 1.00 with median survey intra-service time data of 20 minutes, which results in an IWPUT of 0.028.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 47% No 53%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 43% I do not agree 57%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) 0% no change 14%
C. The usual site-of-service has changed:
   from outpatient to inpatient 14% from inpatient to outpatient 0% no change 86%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: _____

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95953 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **3.50**
RUC RVU: **3.30**

CPT Descriptor: Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-year-old woman with a history of absence seizures and rare generalized tonic clonic seizures has had good control of her seizures for 3 years but may again be experiencing seizures. She seems absent minded at times, and the episodes occur daily according to the patient's mother. The patient denies there is a problem and says she is taking her medication without problems. She wants to begin driver's education. The mother says that symptoms are worse when she is active, out of bed at home. A 24-hour ambulatory digital EEG without video is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 3%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: Determine whether long term portable EEG monitoring is the appropriate test for the patient based on the referral question being asked. Adequately instruct patient and family members on pressing an alarm button during an event.

Description of Intra-Service Work: Supervise patient preparation and performance of the test by the technician. Review the recorded data, assess the normal and abnormal findings, review the patient or family triggered alarms, interpret the data, and provide clinical correlation of the findings based on the patient's history.

Description of Post-Service Work: Generate the report and make recommendations for further management.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Gregory L. Barkley, MD Susan Herman, MD Marc Raphaelson, MD					
Specialty(s):	American Academy of Neurology American Clinical Neurophysiology Society					
CPT Code:	95953					
Sample Size:	55	**Resp n:** 30		**Response:** 54.5 %		
Sample Type:	Convenience					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.00	2.80	**3.50**	3.95	6.00
Pre-Service Evaluation Time:				**10.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		20.00	41.00	**60.00**	68.00	120.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
95813	XXX	1.73

CPT Descriptor Electroencephalogram (EEG) extended monitoring; greater than one hour

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
71275	XXX	1.92

CPT Descriptor 1 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

MPC CPT Code 2	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU
95808	XXX	2.65

CPT Descriptor Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 40.0 %

TIME ESTIMATES (Median)

	CPT Code: 95953	**Key Reference CPT Code: 95813**
Median Pre-Service Time	10.00	15.00
Median Intra-Service Time	60.00	30.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**85.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.58	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.25	4.00
Urgency of medical decision making	3.75	3.67

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.50
Physical effort required	2.25	2.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.92	3.75
Outcome depends on the skill and judgment of physician	4.67	4.75
Estimated risk of malpractice suit with poor outcome	3.50	3.08

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.75	2.36
Intra-Service intensity/complexity	4.17	3.91
Post-Service intensity/complexity	3.58	3.18

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The reference service code chosen by the survey participants, 95813, is not a valid comparison for 95953 because the physician work involved in providing the reference service has increased substantially since it was last surveyed in 1995. In 1995, the reference service did not include video assist or other software, only half the channels existed and the physician could not change montages. The changes in the technology since 1995 have made 95813 a more intense and complex service. The current value of 95813 is based on the service as it was performed in 1995. We believe that the survey participants were comparing 95953 to 95813 at the level of complexity and intensity it is being performed at

today, not as it is valued (i.e., based on the service provided in 1995). Therefore, 95813 cannot be used as a direct comparison for physician work to 95953 and it is more appropriate to determine the physician work through an IWPUT analysis.

A better comparison for 95953 can be made to code 95810 (Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist), which has an RVW of 3.52 and an intra-service time of 60 minutes. We believe that the 95953 service is comparable to the physician work of 95810. For example, 95810 involves monitoring of 8-10 EEG channels over 8 hours, while 95953 requires monitoring of 16 or more EEG channels over 24 hours. The 95953 service also records multiple patient states (e.g., awake and asleep) and EEG patterns. In addition, seizures are more likely to be recorded during the 95953 service, which requires physician analysis of seizure frequency and localization. Additionally, the physician must correlate EEG patterns with a diary kept by the patient and adjust his interpretation based on the underlying EEG patterns.

The median survey data time for 95953 (10 minutes pre-service, 60 minutes intra-service, and 15 minutes post-service) with the median RVW of 3.50 results in an IWPUT of .049. This is consistent with the IWPUT of other comparable services from the MPC list with similar intra-service times such as 95810 (60 minutes intra-service time, RVW = 3.52, IWPUT = 0.046). For these reasons we believe that an RVW of 3.50 with the median service times from the survey data for code 95953 is appropriate.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 50% No 50%

(Use the subset of the people who responded "Yes" to answer the following questions)

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 20% I do not agree 80%
B. Patients requiring this service are now:
   more complex (more work) 67% less complex (less work) 6% no change 27%
C. The usual site-of-service has changed:

from outpatient to inpatient 14% from inpatient to outpatient 13% no change 73%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: _____

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/Specialty Society RVS Update Committee
2005 Five-Year Review of the RBRVS
RUC Recommendations - Evaluation and Management Services

This document discusses the overall historical valuation of the Evaluation and Management (E/M) services; the process utilized to develop recommendations in this Five-Year Review; the E/M Workgroup Review, and the RUC recommendations. An attachment includes the recommendations for each individual E/M code. An Excel spreadsheet is also attached, summarizing the current and recommended physician time and physician work for each code.

Original Valuation of Evaluation and Management Services in 1992

On January 1, 1992, the Health Care Financing Administration (HCFA) implemented the Resource-Based Relative Value Scale (RBRVS) and assigned relative values for new Evaluation and Management codes, first published in *CPT 1992*. The work relative values for E/M were based on three phases of the Harvard study. The Harvard surveys were based on the pre-1992 CPT descriptors (eg, 90015,*Office and other outpatient medical service, new patient; intermediate service*) and typical patient vignettes. HCFA then worked with the Harvard researchers and the CPT Editorial Panel to develop a structure and intra-service time variation for the new 1992 CPT E/M codes.

The work relative values were then assigned to the codes utilizing a crosswalk process based on the typical patient vignettes. After the publication of the Final Rule in the November 25, 1991 *Federal Register,* HCFA received numerous comments that the E/M codes were undervalued. Specialty societies offered a number of different approaches on reviewing the intensity relativity of E/M. These approaches varied from ascending intensity within a family of E/M codes; descending intensity, or equivalent intensity. HCFA concluded that they would not reach consensus within the medical community. HCFA chose to continue to use Harvard data and value the E/M codes in a linear fashion, assigning a fixed intensity of intra-service work across all the codes in an E/M family (eg, office, established patients, and then multiplying that amount by the intra-service time to determine the new intra-service work values. HCFA then computed total work relative values by adding pre- and post-service work, which is calculated as a percentage of the intra-service work (eg, office, established patient = 35.1%). HCFA stated that "in absence of any further data, we do not believe changes more comprehensive than those we have made would be appropriate."

1995 Five-Year Review of the RBRVS

RUC Review:

In 1995, the RUC submitted new data and recommendations to HCFA for E/M codes in response to the first, Five-Year Review of the RBRVS. At that time, Internal Medicine and Family Medicine commented that the E/M codes should be re-evaluated for the following reasons:

- The physician work involved in the E/M services had increased since the time that the Harvard RBRVS study was conducted.
- The E/M services were undervalued relative to most of the other services in the RBRVS.
- The current CPT-coded services were never directly surveyed or studied in the Harvard RBRVS study.

Prior to conducting the surveys and developing relative value recommendations, the specialties involved agreed to the following:

- 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).
- A standard set of reference services were chosen for use in the surveys.
- The issue of whether the intra-service work per unit of time (IWPUT) is the same or different for all levels of service within an E/M family had been addressed by HCFA in November 1992, less than three years prior to this first, Five-Year Review. HCFA had already concluded that IWPUT is constant within a family from the lowest to the highest level of service. Understanding that HCFA had made its decision on this point, the specialties decided to survey one or two codes within each family and then extrapolate to the other codes based on the IWPUT of the surveyed codes, retaining HCFA's decision that a constant IWPUT should be maintained for each level of service.

Approximately 150 respondents were obtained for each surveyed code. A median value was calculated for each specialty, and these values were weighted to develop the recommended work relative values. The 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.

The RUC found the arguments made by the specialties and the results of the survey very compelling and recommended 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 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 example, the RUC agreed that the work of 99215 *Established Office Visit, Level V* should be greater than 12002 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 to 7.5 cm* (work rvu = 1.86, intra-time = 22 minutes; total-time = 43 minutes).

In addition to the survey results, the RUC's recommendations were 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 previous five years and the failure of the current RVUs to appropriately recognize the time and effort involved in both intra- and post-service work. The RUC vote to adopt the recommendations to increase the E/M services was nearly unanimous.

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' rating of work appeared to be accurate. Some problems were noted in the survey results for post-service time, however. Within the survey instrument, the detailed questions related to post-service time appeared to lead to overestimates of total post-service time. This may have been due either to rounding, to overlap within the categories, or just to the tendency of survey respondents to want to fill in all the boxes on a survey. The RUC concluded, therefore, that although post-service time was underestimated in the Harvard survey as it did not reflect post-time in 1995, post-service time was likely overestimated in the RUC survey data. The correct estimate of post-service 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 intra-service 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 post-service time estimates did not affect the extrapolation from surveyed to non-surveyed services within a family, however. Extrapolation was based on work per unit of time, and this remained constant within each family whether the surveyed post-service times were used as is or were reduced by some percentage. The typical times listed in the CPT descriptors were used for this purpose.

HCFA Review:

In the *May 3, 1996 NPRM,* HCFA discussed its review of the RUC recommendations from the first, Five-Year Review of E/M. HCFA concluded that the work relative values for E/M are based on three basic assumptions. These three assumptions originated during the Harvard study and were held constant in both the 1992 and 1995 refinements:

1. All services within a family of evaluation and management services (eg, office visits) have the same intra-service work intensity.
2. The intra-service work times in the CPT descriptors are correct.
3. The pre-service and post-service work is a fixed percentage of intra-service work.

HCFA utilized 1989 and 1994 publications of the AMA's *Physician Marketplace Statistics* to identify that the median number of hours a physician works in patient care (51 hours) and the median number of patient visits per week (101) had not changed between 1989 and 1994. They further used this information to calculate the total number of hours that a physician would need to spend in patient care hours (78.5) to perform 101 visits, based on the 1995 RUC survey data. This was a key argument that HCFA utilized to reject the RUC survey time and recommendations.

Although HCFA did not agree with the RUC recommendations, the agency did agree that the E/M services should be increased. HCFA utilized a different approach to compute these increases. Using the above assumptions, HCFA increased the intra-service work intensity by 10 percent and fixed the percentage of pre- and post-service work in relation to intra-service work by 25%. For example, the intra-service intensity for established office visits was increased from 0.028 to 0.031 and the pre- and post-service work as a percentage of intra-service work was increased from 35.1% to 43.8%.

December 2004 Comment Letter to Initiate 2005 Five-Year Review of E/M

On December 16, 2004, twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first, Five-Year Review in 1995. The specialties provided the following reasons for the change in work in the past ten years:

- Medical practice has changed;
- A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness;
- Additional documentation requirements added to physician work;
- An increase in the complexity of the data to be evaluated and care to be managed;
- Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press;
- The advent of online communication with patients;
- A greater role for genomics in the evaluation and management of patients;
- Environmental changes (eg, increased volume, decreased number of facilities, increased uninsured population, and EMTALA requirements) in the emergency department;
- The intensity of EM services has increased over time;
- Hospital length of stay has changed

The societies also concluded that they believe E/M services are not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) the work per unit of time for E/M services is less than the work per unit of time for almost any other service.

Medical specialty society survey process

A coalition of medical specialty societies conducted surveys related to 35 E/M services over the summer of 2005. Physicians were contacted via e-mail and provided a link to a web-based survey, based on the standard RUC survey instrument. The specialties involved with this effort, coordinated by the medical specialties, included: anesthesiology, critical care medicine, dermatology, emergency medicine, endocrinology, family medicine, hematology, infectious disease, internal medicine, neurology, nursing, oncology, osteopathic medicine, podiatry, pulmonary medicine, and rheumatology. The number of survey respondents for each code ranged from a low of 40 respondents to a high of 245 respondents, with most codes having at least 80 respondents. The survey data were collated and presented with data by individual specialty society to the RUC on August 2, 2005.

Surgical specialty society survey process and coordination with medical specialty coalition

A coalition of surgical specialty societies had expressed an interest in developing recommendations for E/M in April 2005. Following preliminary discussions at the April RUC meeting, a surgical executive committee (SEC) met with a medical executive committee (MEC) to develop a common reference service list and to review and edit vignettes developed by the coalition of medical specialty societies. Several conference calls and e-mail communications were conducted to develop the reference service list and to critique the vignettes. The MEC responded by removing all references to physician work from the vignettes. Vignettes for codes predominately performed by other specialties, such as podiatry and dermatology for 99201 and 99202, were also modified to capture the typical patient evaluated by these specialties. However, complete consensus on the use of a single vignette for each CPT code and for the specific vignettes themselves was not achieved as the SEC continued to express concern regarding the vignettes. The MEC decided that it needed to move forward by initiating their surveys in early June.

The SEC subsequently initiated web-based surveys and planned to meet with the MEC in late July to review all survey data and attempt to come to consensus on a single set of recommendations to the RUC. At some point in mid-July, the SEC realized that their own survey data and analysis concluded that there should be no changes in the work relative values and suggested cancellation of the meeting as they would not be able to support modifications to the valuation of E/M. On August 2, 2005, the following surgical specialties signed a letter outlining their rationale (including summary survey data) for maintaining the current relative values for the E/M services: breast surgery, cardiothoracic surgery, cataract surgery, colon and rectal surgery, general surgery, hand surgery, neurosurgery, obstetrics and gynecology, orthopaedic surgery, otolaryngology, pediatric surgery, plastic surgery, spine surgery, transplant surgery, urology, vascular surgery. The Workgroup agreed that this submission was a "comment" rather than a "recommendation" as the surgical coalition did not submit a breakdown of survey results by specialty society and did not complete the RUC standard Summary of Recommendation forms. This coalition of surgical specialties also sent an additional letter on August 18, 2005 refuting the recommendations to increase the work relative values for E/M, submitted by the coalition of medical specialties.

RUC E/M Five-Year Review Workgroup

The following individuals were members of the RUC's Five-Year Review E/M Workgroup: Norman A. Cohen, MD (Chairman), John Derr, Jr., MD, David F. Hitzeman, DO, George Kwass, MD, Gregory Przybylski, MD, and Maurits J. Wiersema, MD. These individuals met periodically via conference call throughout the summer and also prepared by reviewing a collection of historical information regarding the previous studies and methodologies to evaluate the physician work related to the E/M services. The Workgroup sent a letter to all specialties who had expressed an interest in developing recommendations for E/M on June 7, 2005. This letter laid out the expectations of the Workgroup, including specific questions to be addressed by the specialties in their presentation. The Workgroup also stated that it required the data to be submitted with both overall results and breakdown of results by specialty society. The Workgroup, along with the Chair of the RUC and the Chair of Overall Five-Year Review project, also provided guidance regarding the use of a fair and consistent process to consider the valuation of the E/M services.

The RUC's E/M Five-Year Review Workgroup met on August 27 - 28, 2005 to consider the recommendations presented by the coalition of medical specialties and the comments by the coalition of surgical specialties.

Workgroup Recommendations

The Workgroup initially discussed the RUC's compelling evidence standards and considered the following arguments that were presented by the medical specialty societies:

- Nearly all of the E/M codes under review have never been surveyed with their actual CPT descriptor and a common vignette.
- CMS made incorrect assumptions when these services were evaluated in the 1995 Five-Year Review.
- The 1995 and 1997 E/M Documentation Guidelines have been fully implemented. In the first Five-Year Review, these 1995 documentation guidelines had been introduced, but not implemented. In addition, other insurers and accrediting agencies have required additional documentation.
- New diagnostic and screening tests have been developed in the past ten years, which add to the amount of data that needs to be considered and followed-up on as required.
- An increase in the number of clinical guidelines has occurred in the past ten years.
- A new emphasis on disease management and chronic care management requires more coordination of care with a team of providers.
- Patients are more informed and wish to be more active participants in their decisions regarding their medical care. Patient expectations are higher and they often come to the office armed with incorrect information from the Internet or lay press.
- The National Ambulatory Medical Care Survey (NAMCS), published by the Centers for Disease Control and Prevention, reflects an increasing complexity and intensity of physician work in office practice from 1999-2002. One reason for this increased complexity is the declining length of hospital stay and the treatment of these acute patients in the physician office setting.

The surgical representatives countered that the arguments regarding increased physician work did not reflect external data that state that physicians are not spending more time in E/M services. The NAMCS data suggests that in 1997, physicians spent an average of 18.8 minutes on each visit. In 2002, the visit duration has decreased to 18.4 minutes. The 1989 and 1994 publications of the AMA's Physician Marketplace Statistics indicated that the median number of hours a physician works in patient care is 51 hours per week and the median number of patient visits is 101. The 2001 median number of patient visits per week is 50 hours and the number of patient visits per week is 100. The medical representatives countered that they agree that the amount of intra-service time has not increased. However, the intensity has increased as physicians are required to do more in the same timeframe and the patient population is more complex.

The Workgroup also discussed the increased reporting of the higher level E/M codes and the resulting increased intensity that has been captured in the utilization of these CPT codes. The medical representatives explained that there has been an increase in the number of E/M services reported per beneficiary. In addition, the education regarding the 1995 and 1997 documentation guidelines has resulted in physicians reporting E/M correctly. The 1995 documentation guidelines were based on multi-system exams and the 1997 guidelines provided more flexibility in single system examinations, perhaps leading to more accurate E/M reporting for those specialties that focus on single systems. The medical representatives admitted that they are unable to fully explain the shift in utilization to the higher level E/M codes.

After extensive discussion, the Workgroup agreed that the compelling evidence to review these services is that **there is evidence that incorrect assumptions were made in the previous valuation of the service**. The Workgroup has reviewed the May 1996 *Notice of Proposed Rulemaking (NPRM)* and the HCFA rationale in evaluating the E/M in the 1995 Five-Year Review. Specifically, the Workgroup reviewed the following three assumptions made by HCFA at that time:

1. All services within a family of evaluation and management services (eg, office visits) have the same intra-service work intensity.
2. The intra-service work times in the CPT descriptors are correct.
3. The pre-service and post-service work is a fixed percentage of intra-service work.

The Workgroup also reviewed the RUC comment letter on this NPRM in June 1996, in which the RUC argued that the HCFA valuation of E/M was flawed, stating "The proposed values are based on several questionable assumptions that warrant further

evaluation." The Workgroup agrees that the assumptions made by HCFA are flawed and noted that HCFA stated at that time that "We will remain open to data receiving further information that shows the relationships between some families of these services have changed." The Workgroup agreed that this compelling evidence standard applied to the office visits, hospital visits, and consultations.

The critical care and emergency department visits were not based on the above three assumptions. Therefore, the Workgroup does not believe that this particular compelling evidence standard applies to these two families of services.

During the Workgroup meeting, the medical specialties and the surgical specialties provided additional information for consideration by the Workgroup. Because the Workgroup did not have adequate time to review this additional data during the limited period available for Workgroup deliberation, the Workgroup agreed to accept both submissions for informational purposes only.

The Workgroup reviewed each E/M code extensively, reviewing the survey from the coalition of medical specialties, comparing the codes to reference services, and considering comments from the surgical coalition and other meeting attendees. The Workgroup's specific E/M code recommendations were presented to the RUC on September 29 – October 2, 2005.

RUC Recommendations

The RUC agreed with the Workgroup that one of the compelling evidence standards was met and warranted the review of the E/M services. The RUC agreed that the compelling evidence to review these services is that **there is evidence that incorrect assumptions were made in the previous valuation of the service**.

This Five-Year Review included 47 E/M codes. **The detailed rationale for the recommendations for each code are attached to this document.** Twelve of these codes (nursing facility and domiciliary care) were referred to CPT and reviewed by the RUC at the April 2005 meeting. CMS will consider the RUC recommendations for these two families in their November 1, 2005 Final Rule, for implementation on January 1, 2006. On October 1-2, 2005, the RUC approved final recommendations for 26 codes, interim recommendations for 6 codes (99222, 99223, 99232, 99233, 99291, and 99291), and postponed review of 3 codes (99213, 99214, 99215) to the February 2006 meeting. The RUC now submits all of these recommendations to CMS for consideration for the Spring 2006 Proposed Rule. It is anticipated that the RUC will forward additional information and/or recommendations to CMS on the six interim and three postponed codes immediately following the February RUC meeting.

The RUC anticipates that it will review updated or refined survey data on the six codes submitted with "interim" values. The RUC's Rules and Procedures state the following regarding RUC "interim" recommendations:

The RUC may develop an "interim" relative value unit(s). If the RUC adopts an "interim" work relative value unit, the associated specialty society will be expected to present updated or refined survey data to the RUC at the next RUC meeting. If no subsequent data is presented which validates the interim values, the work relative unit will be deemed "not validated," and CMS will be notified as such.

The RUC has postponed review of CPT codes 99213, 99214, and 99215 is to allow continued review, discussion, and reflection so the RUC may reach an appropriate resolution of this issue at the February 2006 RUC meeting.

AMA/Specialty Society RVS Update Committee
RBRVS 2005 Five-Year Review: Evaluation and Management

CPT Code	*Descriptor*	*2005 work RVU*	*RUC Rec Work RVU*	*Comment from the Public*	*Workgroup Rationale*	*Change in Time from 2005?*	*Action Key*
99201	Office/outpatient visit, new	0 45	0.45	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	The specialty societies did not request a change in the physician work for this service 99201 had never been surveyed prior to this effort This survey, with more than 200 respondents, confirmed the CPT intra-service time of 10 minutes The survey also indicated minimal pre and post service time of 3 and 5 minutes, respectively In addition, 57% of the survey respondents indicated that the work of performing this service had not changed in the past five years A comparison was made to 99341, Home Visit, Level 1 (work = 1 01, time: pre = 7, intra = 20, post = 10), which indicated that 99201 requires one-half the physician time as 99341. In addition, the work of 99201 is similar to the work of 99212, Office Visits, Level 2 (recommended work = .45, pre=3, intra=10, post=5). A work relative value of .45 and time of pre = 3, intra = 10, and post = 5 are recommended for 99201. The current CPT time of 10 minutes is recommended to be maintained.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99202	Office/outpatient visit, new	0.88	0.88	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	The specialty societies did not request a change in the physician work for this service 99202 had never been surveyed prior to this effort. This survey, with more than 200 survey respondents, indicates that the CPT intra-time of 20 minutes may be slighty overstated, indicating that 15 minutes is typical. The dominant providers of this service, dermatology and podiatry, were represented in the survey and the consensus panel process and agreed that 15 minutes is a more appropriate reflection of the actual intra-service time for 99202. The survey time of pre and post time of 5 minutes each confirm the current total pre/post time of 10 minutes In addition, 51% of the survey respondents indicated that the work of performing the service has not changed in the past five years. A comparison was made to 99341 Home Visit, Level 1 (work = 1.01; time· pre = 7, intra = 20, post = 10), which indicated that 99202 requires less physician time than the home visit service. A work relative value of .88 and time of pre = 5, intra = 15, and post =5 are recommended for 99202. A change in the CPT time to 15 minutes is also recommended.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99203	Office/outpatient visit, new	1.34	1.34	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	A survey was conducted for this service, however, it was determined that the vignette utilized was flawed in that it referred to a patient that would be more reflective of 99386 Initial Preventive Medicine Visit, 40-64 years (work = 1.88; time: pre = 5, intra = 40, post = 10) The survey respondents selected 99386 as their key reference service, most likely due to the vignette that was utilized in the survey. 99386 requires 15 minutes more intra-service time than 99203, and therefore, is not the same amount of physician work. Although, there were fundamental problems with the vignette utilized for this code, it is possible to evaluate and validate the current work relative value of 1 34 for this service. The work of 99203 is similar to 99242 Office Consultation (recommended work = 1 34; pre = 5, intra =25 , post = 10) and 99214 Established Office Visit, Level 4 (recommended work = 1 30, pre = 5, intra = 25, post = 10). Although 70% of survey respondents indicated that they believed the physician work had changed, the survey data and comparison to other EM services does not support an increase. A work relative value of 1 34 and time of pre = 5, intra = 25, and post = 10 minutes) is recommended for 99203. A change in the CPT time to 25 minutes is also recommended	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99204	Office/outpatient visit, new	2.00	2.30	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work, 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	The survey vignette and reference service, 99386 Initial Preventive Visit, 40-64 years (work relative value = 1 88, pre = 5, intra = 40, post = 10) were reasonable. The RUC agreed that an appropriate work relative value would be between the 25th percentile (2.03) and the median (2 78) for this service The RUC agreed that this service is slightly more work than 90880 Hypnotherapy (work rvu = 2 19) and 99343 Home visit, new patient (work rvu = 2 27). A work relative value of 2.30 and time of pre = 5, intra = 40, and post = 12 minutes) is recommended for 99204. A change in the CPT time to 40 minutes is also recommended.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99205	Office/outpatient visit, new	2.67	3.00	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	The survey vignette appeared reasonable for this service. An inappropriate service was selected as the key reference point, however. 99236 Observation Care (work rvu = 4 26; total time = 110) greatly exceeds the total physician survey time of 75 minutes for code 99205 The survey 25th percentile of 3 00 is a more appropriate reflection of the physician work for this service This compares well to 99344 Home Visit (work rvu = 3 03; time: pre = 15, intra = 60, post = 25). A work relative value of 3.00 and time of pre = 10, intra = 50, and post = 15 minutes) is recommended for 99205. A change in the CPT time to 50 minutes is also recommended	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99211	Office/outpatient visit, est	0.17	0 17	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients, 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	The specialty societies did not request a change in the physician work for this service This service does include a small amount of physician work. It is estimated that physicians spend approximately 5 minutes of intra time supervising staff and addressing questions. Approximately three minutes of physician time is spent in the post service period related to chart review and revising treatment plans A work relative value of 0.17 and time of pre = 0, intra = 5, and post = 3 minutes) is recommended for 99211 The current CPT time of 5 minutes is recommended to be maintained	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99212	Office/outpatient visit, est	0.45	0 45	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department, 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	Although the survey of 243 physicians indicated a survey 25th percentile and median work relative value in excess of the current work rvu, an increase is not supported by the physician time data and other survey responses. Nearly 60% of the survey respondents indicated that the work had not increased for this service. The current work rvu of 0.45 is supported in comparison to codes 76005 (recommended work rvu = 60; time pre = 10, intra = 20, post = 5) , 95903 (recommended work rvu = 0.60 , time. pre = 8, intra = 10, post = 10), and 97110 (recommended work rvu = .45; time pre = 2, intra = 14, post = 2). In addition, the work of 99212 is similar to the work of 99201 New Office Visit, Level 1 (recommended work rvu = 0 45; time: pre = 3, intra = 10, post = 5). A work relative value of .45 and time of pre = 3, intra = 10, and post =5 are recommended for 99212. The current CPT time of 10 minutes is recommended to be maintained.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99213	Office/outpatient visit, est	0.67		Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work, 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	The RUC has postponed review of CPT codes 99213, 99214, and 99215 is to allow continued review, discussion, and reflection so the RUC may reach an appropriate resolution of this issue at the February 2006 RUC meeting.	☑	6

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99214	Office/outpatient visit, est	1.10		Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work, 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	The RUC has postponed review of CPT codes 99213, 99214, and 99215 is to allow continued review, discussion, and reflection so the RUC may reach an appropriate resolution of this issue at the February 2006 RUC meeting.	☑	6

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99215	Office/outpatient visit, est	1.77		Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients, 8) Environmental changes in the emergency department, 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	The RUC has postponed review of CPT codes 99213, 99214, and 99215 is to allow continued review, discussion, and reflection so the RUC may reach an appropriate resolution of this issue at the February 2006 RUC meeting.	☑	6

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99221	Initial hospital care	1.28	1.88	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	The survey instrument included a flawed vignette. This vignette, describing a patient with low back pain, is not typical for a 99221 and should not be included in the RUC database The reference service 99234 Observation Care (work rvu = 2.56, time: pre = 10, intra = 60, and post = 15) selected is also not appropriate as this code includes an admission and discharge and requires significantly more time than 99221 (53 minutes total) A more appropriate reference service is 99386 (work rvu = 1.88, time: pre = 5, intra = 40 post = 10) The survey 25th percentile of 1 88 appears more appropriate to utilize to value 99221 99221 is also more work than 99203 New Office Visit, Level III (work rvu = 1.34; time pre = 5, intra = 25 , post =10), considering both time and intensity A work relative value of 1.88 and time of pre = 10, intra = 30, and post = 13 minutes) is recommended for 99221. A change in the CPT time to 30 minutes is also recommended.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99222	Initial hospital care	2.14	2.56	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	More than eighty percent of the survey respondents indicated that the work in performing this service had changed. However, the reference service selected was not appropriate as 99235 Observation Care (work rvu = 3.41, time: pre = 10, intra = 75, post = 15) requires 100 minutes of total time, compared to a total survey time of 75 minutes for 99222. A more appropriate reference service is 99234 Observation Care (work rvu = 2 56; time pre = 10, intra = 60, post = 15). 99222 requires more work than the following services 90847 Family psychotherapy (work rvu = 2.21; time: pre = 5, intra = 50, post = 21), 99343 (work rvu = 2 27 ; time: pre = 15, intra = 50 , post = 17); and 99299 (work rvu = 2.50; time: pre = 10, intra = 30, post = 15). 99222 is more intense that 99204 New Office Visit, Level 4 (recommended work rvu = 2.03, time pre = 5, intra = 40, post = 12) Considering all of these comparisons, it appears that a crosswalk to 99234 is most appropriate. A work relative value of 2.56 and time of pre = 15, intra = 40, and post = 20 minutes) is recommended for 99222. A change in the CPT time to 40 minutes is also recommended. The RUC considers this recommendation "interim" and will review updated or refined data for this code at the February 2006 RUC meeting	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99223	Initial hospital care	2.99	3.78	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department, 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	More than ninety percent of the survey respondents indicated that the work in performing this service had changed. However, the reference service selected was not appropriate as 99236 Observation Care (work rvu = 4.26) as this code includes an admission and discharge A more appropriate reference service is 99345 Home Visit (work rvu = 3.78, time: pre = 50, intra = 90, post = 30). A work relative value of 3.78 and time of pre = 20, intra = 55, and post = 25 minutes) is recommended for 99223. A change in the CPT time to 55 minutes is also recommended The RUC considers this recommendation "interim" and will review updated or refined data for this code at the February 2006 RUC meeting.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99231	Subsequent hospital care	0.64	0.76	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work, 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	Approximately sixty percent of the 60 survey respondents indicated that the work of performing this service had increased. The presenters argued that as the average length of hospital stay has declined, the subsequent hospital visits have become more intense. The survey respondents most frequently chose 99347 Home Visit (work rvu = 0 76; time: pre = 5, intra = 15, post = 10) as the reference service. During the first, Five-Year Review the RUC determined that 99213 required more work than 99231, and the current recommendations reflect this relationship. 99231 is also more work than 99433 Subsequent Newborn Care (work rvu = 0.62; time: pre = 3, intra = 15, post = 2). A work relative value of 0 76 and time of pre = 5, intra = 15, and post = 5 minutes) is recommended for 99231. The current CPT time of 15 minutes is recommended to be maintained.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99232	Subsequent hospital care	1 06	1.30	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	Approximately ninety percent of the 60 survey respondents indicated that the work of performing this service had increased. The presenters argued that as the average length of hospital stay has declined, the subsequent hospital visits have become more intense. The reference service (99235 Observation Care, work rvu = 3.41, time: pre = 10, intra = 75, and post = 15)) selected is also not appropriate as this code includes an admission and discharge and requires significantly more time than 99232 (40 minutes total). In the first, Five-Year Review of the RBRVS, the RUC recommended 1.30 for this service. CPT code 99348 (work rvu = 1 26, time: pre = 9, intra = 30, post = 10) is a more appropriate reference service. The work of 99232 is similar to 99214 (recommended work rvu = 1 30; time: pre = 5, intra = 25, post = 10) A work relative value of 1.30 and time of pre = 10, intra = 20, and post = 10 minutes) is recommended for 99232. A change in the CPT time to 20 minutes is also recommended. The RUC considers this recommendation "interim" and will review updated or refined data for this code at the February 2006 RUC meeting.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99233	Subsequent hospital care	1.51	2.00	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department, 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	Approximately ninety percent of the 60 survey respondents indicated that the work of performing this service had increased The presenters argued that as the average length of hospital stay has declined, the subsequent hospital visits have become more intense. The reference service (99236 Observation Care, work rvu = 4.26; total time = 110 minutes) selected is also not appropriate as this code includes an admission and discharge and requires significantly more time than 99233 (50 minutes total) A more appropriate reference service is 99349 (work rvu = 2 02; time: pre = 10, intra = 40, post = 15. The work of 99233 is similar to 99215 (recommended work rvu = 2 00, time: pre = 8, intra = 35, post = 15) The 25th percentile of the survey at 2.00 appears appropriate A work relative value of 2 00 and time of pre = 10, intra = 25, and post = 15 minutes) is recommended for 99233 A change in the CPT time to 25 minutes is also recommended. The RUC considers this recommendation "interim" and will review updated or refined data for this code at the February 2006 RUC meeting.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99238	Hospital discharge day	1.28	1.28	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients, 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	Although nearly 80% of the 40 survey respondents indicated that the physician work had changed for this service, the survey data does not support an increase. The survey respondents most often selected 99235 as a reference service. This selection is inappropriate as 99235 (work rvu = 3 41; time· pre = 10, intra = 75, post = 15) includes an admission and discharge and the total time of 100 far exceeds the survey total time of 39 minutes for 99238 The current value of 1.28 should be maintained for 99238. The survey data of pre = 9, intra = 20, and post = 10 minutes are recommended.	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99239	Hospital discharge day	1.75	1 90	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	Nearly 100% of the 40 survey respondents indicated that the patients are not more complex that require the longer discharge day management. The survey respondents most often selected 99236 Observation Care (work rvu = 4.26, total time = 110 minutes), which is inappropriate as it includes both admission and discharge services and twice the total survey time of 55 minutes for 99239. A more appropriate reference service is 99375 Home Health Supervision (work rvu = 1 73; time pre = 10, intra = 32 , post = 15) Although, the times for 99239 and 99375 are similar, the work intensity of 99239 is greater than 99375, supporting the use of the 25th percentile of the survey median is 1.90 as more appropriate for this service A work relative value of 1.90 and time of pre = 10, intra = 30, and post = 15 minutes) is recommended for 99239.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99241	Office consultation	0.64	0.64	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years· 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	More than 50% of the 94 survey respondents indicated that the patients requiring this service are not more complex. The patient population as defined by the vignette has not changed in intensity over the past five-years. The survey data also did not indicated an increase in intra-service time. The current relative value of 0 64 is appropriate in relationship to 99202 New Office Visit, Level II (work rvu = 0.88; time pre = 5, intra = 15, post = 5) as the intensity is greater in 99202 than 99241 In addition, 99347 Home Visit (work rvu = 0.76; time: pre = 5, intra = 15, and post = 10) also requires greater physician work than 99241. 99241 also requires less work than 99231 Subsequent Hospital Visit (work rvu = 0.76; time: pre = 5, intra = 15, post = 5). A work relative value of 0.64 and time of pre = 5, intra = 15, and post = 5 minutes) is recommended for 99241. The current CPT time of 15 minutes is recommended to be maintained	☑	2

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99242	Office consultation	1.29	1.34	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	Approximately 60% of the survey respondents indicated that the patients for this service had become more complex. However, the reference service selected by the respondents 99387 Preventive Medicine Visit, 65 years or older (work rvu = 2.06; time: pre = 5, intra = 45, post = 10) requires 60 minutes of total physician time versus the survey total time of 40 minutes for 99242. Utilizing the intensity of 99387, the 25th percentile of the survey of 1 34 appears reasonable The work of 99242 is also similar to 99203 New Office Visit, Level III (work rvu = 1.34, time. pre = 5, intra = 25, post = 10). A work relative value of 1.34 and time of pre = 5, intra = 25, and post = 5 minutes) is recommended for 99242. A change in the CPT time to 25 minutes is also recommended.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99243	Office consultation	1 72	1.88	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work, 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department, 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	More than eighty percent of the survey respondents indicated that the physician work for this service had increased and chose as their reference service 99386 Preventive medicine visit, age 40-64 (work rvu = 1.88, time. pre = 5, intra = 40, post = 10). The RUC also compared this service to 45340 Sigmoidoscopy, flexible; with dilation by balloon, 1 or more strictures (work relative value = 1 89, time. pre = 17, intra = 25, and pos = 16) A work relative value of 1.88 and time of pre = 10, intra = 35, and post = 10 minutes) is recommended for 99243 A change in the CPT time to 35 minutes is also recommended	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99244	Office consultation	2.58	3.02	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	Nearly 100% of the 94 survey respondents indicated that the work of 99244 had increased. The survey median of 3.02 for this service appears reasonable in comparison to several reference services, including: 90801 Psychiatric diagnostic interview (work rvu = 2.80, time pre = 10, intra = 60, and post = 55); 93503 Insertion of Swan-Ganz (work rvu = 2 91, time: pre = 20, intra = 30, post = 45); and 99205 New Office Visit (recommended work rvu = 3.00; time: pre = 10, intra = 50, post = 15) It was determined 99244 is more intense than 99205 and the recommended relativity appeared appropriate A work relative value of 3.02 and time of pre = 10, intra = 45, and post = 15 minutes) is recommended for 99244 A change in the CPT time to 45 minutes is also recommended	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99245	Office consultation	3 42	3.77	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients, 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	More than 90% of the 94 survey respondents indicated that the work of 99245 had increased. The 25th percentile of the survey, work rvu = 3.77, appeared to be more appropriate than the survey median. 99245 is similar in total physician work to 99223 Initial Hospital Visit (recommended work rvu = 3 78; time. pre = 20, intra = 55, post = 25), although the hospital visit is a more intense service. Another reference service is 99345 Home Visit (work rvu = 3.78, time: pre = 15, intra = 90, post = 30). A work relative value of 3.77 and time of pre = 15, intra = 60, and post = 20 minutes) is recommended for 99245. A change in the CPT time to 60 minutes is also recommended.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99251	Initial inpatient consult	0.66	1.00	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	Although the survey vignette was flawed for this survey, it is possible to determine an appropriate work relative value for this code. The vignette may not be the typical patient and it is recommended that this vignette not be included in the RUC database for this code. The 25th percentile of the survey for work of 1.00 appears reasonable when compared to 99341 Home Visit (work rvu = 1.01, time: pre = 6 5, intra = 20, post = 10). The pre and post time for both the office consultation 99241 and the hospital consultation 99251 are similar, therefore, it is appropriate to reduce the survey time for 99251 to 5 minutes pre-time and 5 minutes post-time. A work relative value of 1.00 and time of pre = 5, intra = 20, and post = 5 minutes) is recommended for 99251. The current CPT time of 20 minutes is recommended to be maintained	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99252	Initial inpatient consult	1.32	1.50	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	Although approximately seventy percent of the 45 survey respondents indicated that the work of this service had changed, an inappropriate reference service was selected. Code 99235 Observation Care (work rvu = 3 41; time: pre = 10, intra = 75, post = 15) describes both an admission and discharge and requires twice the physician time than indicated for 99252 per the survey data The 25th percentile at 1 50 is more reflective of the work for this service when compared to the following reference services: 99396 Preventive Medicine Visit, 40-64 years (work rvu = 1.52; time. pre = 5, intra = 30, post =10); and 99342 Home Visit (work rvu = 1 52 / ruc had recommended = 1.33; time. pre = 10, intra = 30, post = 12). The pre and post time for both the office consultation 99242 and the hospital consultation 99252 are similar, therefore, it is appropriate to reduce the survey time for 99252 to 5 minutes pre-time and retain 10 minutes post-time. A work relative value of 1 50 and time of pre = 5, intra = 35, and post = 10 minutes) is recommended for 99252 A change in the CPT time to 35 minutes is also recommended.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99253	Initial inpatient consult	1 82	2.27	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	More than seventy-five percent of the 50 survey respondents indicated that the work of this service had changed The reference service selected was inappropriate as 99234 Observation Care (work rvu = 2.56; time pre = 10, intra = 60, post =15) includes the admission and discharge and requires 50% more intra-service time than the surveyed time of 40 minutes for 99253. A more appropriate reference service is 99343 Home Visit (work rvu = 2 27, time: pre = 15, intra = 50, and post = 17), which falls between the survey 25th percentile of 2.00 and the median of 2.50 A work relative value of 2.27 and time of pre = 10, intra = 40, and post = 15 minutes) is recommended for 99253. A change in the CPT time to 40 minutes is also recommended.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99254	Initial inpatient consult	2 64	3.29	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	Nearly 85% of the 50 survey respondents indicated that the work in providing this service had changed A work relative value between the 25th percentile of 3 00 and the median of 3.50 is appropriate and can be supported by comparing 99254 to the following reference services· 99344 Home Visit (work rvu = 3 03, time pre = 15, intra = 60, post = 25); and 99235 Observation Care (work rvu = 3.41; time: pre = 10, intra = 75; post = 15) A work relative value of 3.29 and time of pre = 15, intra = 50, and post = 20 minutes) is recommended for 99254. A change in the CPT time to 50 minutes is also recommended.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99255	Initial inpatient consult	3.64	4 00	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients, 8) Environmental changes in the emergency department, 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	Nearly 100% of the 50 survey respondents indicated that the work in providing this service had changed The work relative value 25th percentile of 4.00 can be supported by comparing 99255 to 99236 Observation Care (work rvu = 4.26, total time = 110 minutes) 99255 is less intense than 99236 A work relative value of 4 00 and time of pre = 20, intra = 60, and post = 25 minutes) is recommended for 99255. A change in the CPT time to 60 minutes is also recommended	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99281	Emergency dept visit	0.33	0.45	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work, 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department, 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	The RUC agreed that the original assumptions utilized in valuing the Emergency Department visits were flawed In addition, the RUC's recommendations on the new patient office visits (99201 - 99205) would create a rank order problem if the Emergency Department codes were not addressed In the first Five-Year Review of the RBRVS, the RUC had recommended that the first 3 levels of Emergency Department services should be valued equivalent to the first three levels of new patient office visits. The RUC had further recommended that Emergency Department levels 4 and 5 should be valued higher than the level 4 and 5 new patient officie visits. The RUC reaffirms its previous recommendations with this submitted recommendation. Accordingly, the RUC recommends that 99281 be valued equivalent to 99201, with a recommended work rvu of 0.45 and recommended time as follows: pre = 2, intra = 7, post = 4.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99282	Emergency dept visit	0 55	0.88	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness, 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients, 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	The RUC agreed that the original assumptions utilized in valuing the Emergency Department visits were flawed. In addition, the RUC's recommendations on the new patient office visits (99201 - 99205) would create a rank order problem if the Emergency Department codes were not addressed. In the first Five-Year Review of the RBRVS, the RUC had recommended that the first 3 levels of Emergency Department services should be valued equivalent to the first three levels of new patient office visits. The RUC had further recommended that Emergency Department levels 4 and 5 should be valued higher than the level 4 and 5 new patient officie visits. The RUC reaffirms its previous recommendations with this submitted recommendation. Accordingly, the RUC recommends that 99282 be valued equivalent to 99202, with a recommended work rvu of 0.88 and recommended time as follows. pre = 3, intra = 10, post = 5.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99283	Emergency dept visit	1.24	1.34	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	The RUC agreed that the original assumptions utilized in valuing the Emergency Department visits were flawed In addition, the RUC's recommendations on the new patient office visits (99201 - 99205) would create a rank order problem if the Emergency Department codes were not addressed In the first Five-Year Review of the RBRVS, the RUC had recommended that the first 3 levels of Emergency Department services should be valued equivalent to the first three levels of new patient office visits. The RUC had further recommended that Emergency Department levels 4 and 5 should be valued higher than the level 4 and 5 new patient office visits. The RUC reaffirms its previous recommendations with this submitted recommendation Accordingly, the RUC recommends that 99283 be valued equivalent to 99203, with a recommended work rvu of 1 34 and recommended time as follows: pre = 5, intra = 18, post = 7	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99284	Emergency dept visit	1 95	2 56	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed. The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years, 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	The RUC agreed that the original assumptions utilized in valuing the Emergency Department visits were flawed In addition, the RUC's recommendations on the new patient office visits (99201 - 99205) would create a rank order problem if the Emergency Department codes were not addressed. In the first Five-Year Review of the RBRVS, the RUC had recommended that the first 3 levels of Emergency Department services should be valued equivalent to the first three levels of new patient office visits. The RUC had further recommended that Emergency Department levels 4 and 5 should be valued higher than the level 4 and 5 new patient office visits. The RUC reaffirms its previous recommendations with this submitted recommendation Accordingly, the RUC recommends that 99284 be valued higher than 99204 (work rvu = 2 30), with a recommended work rvu of 2.56 and recommended time as follows. pre = 5, intra = 25, post = 10 This recommendation is based on the 25th percentile of the survey The 25th percentile of 2.56 is between 99204 (rec. work rvu = 2 30) and 99244 (rec work rvu = 3 02), which appears appropriate	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99285	Emergency dept visit	3 06	3.80	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years· 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients, 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service.	The RUC agreed that the original assumptions utilized in valuing the Emergency Department visits were flawed In addition, the RUC's recommendations on the new patient office visits (99201 - 99205) would create a rank order problem if the Emergency Department codes were not addressed In the first Five-Year Review of the RBRVS, the RUC had recommended that the first 3 levels of Emergency Department services should be valued equivalent to the first three levels of new patient office visits. The RUC had further recommended that Emergency Department levels 4 and 5 should be valued higher than the level 4 and 5 new patient office visits. The RUC reaffirms its previous recommendations with this submitted recommendation Accordingly, the RUC recommends that 99285 be valued higher than 99205 (work rvu = 3.00), with a recommended work rvu of 3.80 and recommended time as follows pre = 8, intra = 40, post = 15. This recommendation is based on the 25th percentile of the survey The 25th percentile of 3 80 is between 99205 (rec. work rvu = 3 00) and 99255 (rec work rvu = 4.00), which appears appropriate.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99291	Critical care, first hour	3.99	4.29	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years: 1) Medical practice has changed, 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work, 4) An increase in the complexity of the data to be evaluated and care to be managed; 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press; 6) The advent of online communication with patients, 7) A greater role for genomics in the evaluation and management of patients, 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time; 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded; and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	Unlike other E/M services under review, an argument that the current valuation of critical care was based on a flawed assumption was not presented. In fact, these services have been reviewed by the RUC on a number of occasions. The rationale that the patient population is more complex does not meet the compelling evidence standards as one could argue that services provided to patients as a whole have become more complex. No evidence was presented that critical care services differ greatly in their increased complexity from other services However, in order to prevent a rank order anomaly, it is recommended that 99291 be increased to the 25th percentile of the survey median, 4 29, to retain its relationship to 99255 Inpatient Consultation (recommended work rvu = 4.00). The recommended time is pre = 15, intra = 40, and post = 20. It should be noted that there was a great deal of discussion regarding the CPT definition of time and the RUC survey instrument definition of time The two descriptions appear consistent as any time spent on the floor, including time spent with the patient's family and other activities more typically thought of as pre and post service work, are included in the intra-service time Time away from the patient's floor could be captured as pre and post time. The RUC recommends that this recommendation be considered interim until the February 2006 RUC meeting.	☑	4

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99292	Critical care, addl 30 min	2.00	2.15	Twenty-seven specialties presented a consensus comment letter to CMS stating that the work of E/M services has changed significantly since these codes were reviewed during the first five-year review. The specialties provided the following reasons for the change in work in the past ten years. 1) Medical practice has changed; 2) A greater expectation that physicians will be proactive in disease prevention, as well as diagnosing and treating illness; 3) Additional documentation requirements added to physician work; 4) An increase in the complexity of the data to be evaluated and care to be managed, 5) Patients presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press, 6) The advent of online communication with patients; 7) A greater role for genomics in the evaluation and management of patients; 8) Environmental changes in the emergency department; 9) The intensity of E/M services has increased over time, 10) Hospital length of stay has changed The societies also concluded that they believe E/M services not appropriately valued as 1) the intensity, complexity, and duration of intra-service medical care had increased in the past ten years; 2) the intensity, complexity, and duration of the pre- and post-service time has expanded, and 3) The work per unit of time for E/M services is less than the work per unit of time for almost any other service	Unlike other E/M services under review, an argument that the current valuation of critical care was based on a flawed assumption was not presented. In fact, these services have been reviewed by the RUC on a number of occasions. The rationale that the patient population is more complex does not meet the compelling evidence standards as one could argue that services provided to patients as a whole have become more complex No evidence was presented that critical care services differ greatly in their increased complexity from other services. However, in order to prevent a rank order anomaly, it is recommended that 99291 be increased to the 25th percentile of the survey median, 4 29, to retain its relationship to 99255 Inpatient Consultation (recommended work rvu = 4 00) 99292 should also then be increased to be reflective of 50% of the work of 99291, or 2.15 work rvus. 30 minutes of intra-service time is recommended for this add-on code. The RUC recommends that this recommendation be considered interim until the February 2006 RUC meeting	☑	4
99301	Nursing facility Care	1.20		The AMDA recommended, and then obtained, revisions to the nursing facility codes for CPT 2006 AMDA commented that these services are currently undervalued in comparison to comparable levels of Inpatient Hospital Care.	CPT Editorial Panel approved coding changes to this section of CPT in February 2005 The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005. These codes and new relative values will be implemented on January 1, 2006	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99302	Nursing facility Care	1.61		The AMDA recommended, and then obtained, revisions to the nursing facility codes for CPT 2006. AMDA commented that these services are currently undervalued in comparison to comparable levels of Inpatient Hospital Care	CPT Editorial Panel approved coding changes to this section of CPT in February 2005 The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005 These codes and new relative values will be implemented on January 1, 2006.	☐	5
99303	Nursing facility Care	2.01		The AMDA recommended, and then obtained, revisions to the nursing facility codes for CPT 2006 AMDA commented that these services are currently undervalued in comparison to comparable levels of Inpatient Hospital Care	CPT Editorial Panel approved coding changes to this section of CPT in February 2005. The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005. These codes and new relative values will be implemented on January 1, 2006.	☐	5
99311	Nursing fac care, subseq	0 60		The AMDA recommended, and then obtained, revisions to the nursing facility codes for CPT 2006 AMDA commented that these services are currently undervalued in comparison to comparable levels of Inpatient Hospital Care.	CPT Editorial Panel approved coding changes to this section of CPT in February 2005. The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005. These codes and new relative values will be implemented on January 1, 2006	☐	5
99312	Nursing fac care, subseq	1.00		The AMDA recommended, and then obtained, revisions to the nursing facility codes for CPT 2006. AMDA commented that these services are currently undervalued in comparison to comparable levels of Inpatient Hospital Care	CPT Editorial Panel approved coding changes to this section of CPT in February 2005. The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005. These codes and new relative values will be implemented on January 1, 2006.	☐	5
99313	Nursing fac care, subseq	1.42		The AMDA recommended, and then obtained, revisions to the nursing facility codes for CPT 2006 AMDA commented that these services are currently undervalued in comparison to comparable levels of Inpatient Hospital Care.	CPT Editorial Panel approved coding changes to this section of CPT in February 2005 The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005 These codes and new relative values will be implemented on January 1, 2006	☐	5
99321	Rest home visit, new patient	0.71		The AAHCP recommended, and then obtained, revisions to the domiciliary care codes for CPT 2006. AAHCP commented that these services should be re-valued to be similar to the corresponding home visit codes.	CPT Editorial Panel approved coding changes to this section of CPT in February 2005. The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005. These codes and new relative values will be implemented on January 1, 2006	☐	5

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CPT Code	Descriptor	2005 work RVU	RUC Rec Work RVU	Comment from the Public	Workgroup Rationale	Change in Time from 2005?	Action Key
99322	Rest home visit, new patient	1.01		The AAHCP recommended, and then obtained, revisions to the domiciliary care codes for CPT 2006. AAHCP commented that these services should be re-valued to be similar to the corresponding home visit codes.	CPT Editorial Panel approved coding changes to this section of CPT in February 2005 The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005. These codes and new relative values will be implemented on January 1, 2006.	☐	5
99323	Rest home visit, new patient	1.28		The AAHCP recommended, and then obtained, revisions to the domiciliary care codes for CPT 2006. AAHCP commented that these services should be re-valued to be similar to the corresponding home visit codes.	CPT Editorial Panel approved coding changes to this section of CPT in February 2005. The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005. These codes and new relative values will be implemented on January 1, 2006	☐	5
99331	Rest home visit, est patient	0 60		The AAHCP recommended, and then obtained, revisions to the domiciliary care codes for CPT 2006. AAHCP commented that these services should be re-valued to be similar to the corresponding home visit codes.	CPT Editorial Panel approved coding changes to this section of CPT in February 2005 The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005 These codes and new relative values will be implemented on January 1, 2006	☐	5
99332	Rest home visit, est patient	0.80		The AAHCP recommended, and then obtained, revisions to the domiciliary care codes for CPT 2006. AAHCP commented that these services should be re-valued to be similar to the corresponding home visit codes.	CPT Editorial Panel approved coding changes to this section of CPT in February 2005. The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005. These codes and new relative values will be implemented on January 1, 2006	☐	5
99333	Rest home visit, est patient	1 00		The AAHCP recommended, and then obtained, revisions to the domiciliary care codes for CPT 2006. AAHCP commented that these services should be re-valued to be similar to the corresponding home visit codes	CPT Editorial Panel approved coding changes to this section of CPT in February 2005. The RUC reviewed these services in April 2005 and submitted recommendations to CMS in May 2005 These codes and new relative values will be implemented on January 1, 2006.	☐	5

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RUC E/M Re ,mendations

	A	B	C	D	E	F	G	I	J	K	L	M	N	O	AF	AG	AH
1		Existing Data - RUC database						CPT	Workgroup Recommendations						RUC Recommendations		
2	Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Calc IWPUT	Time	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	IWPUT	Work RVU	IWPUT	
3	**Office, new**																
4	**99201**		10		15	0.45	0.034	10	**3**	**10**	**5**	**18**	**0.45**	**0.027**	**0.45**	**0.027**	
5	**99202**		20		30	0.88	0.033	20	**5**	**15**	**5**	**25**	**0.88**	**0.044**	**0.88**	**0.044**	
6	**99203**	5	24	24	53	1.34	0.029	30	**5**	**25**	**10**	**40**	**1.34**	**0.040**	**1.34**	**0.040**	
7	**99204**		45		68	2.00	0.033	45	**5**	**40**	**12**	**57**	**2.03**	**0.041**	**2.30**	**0.048**	
8	**99205**	10	45	55	110	2.67	0.027	60	**10**	**50**	**15**	**75**	**3.00**	**0.049**	**3.00**	**0.049**	
9	**Office, estab**																
10	**99211**		5	2	7	0.17	0.025	5	**0**	**5**	**3**	**8**	**0.17**	**0.021**	**0.17**	**0.021**	
11	**99212**		10	5	15	0.45	0.034	10	**3**	**10**	**5**	**18**	**0.45**	**0.027**	**0.45**	**0.027**	
12	**99213**		15	8	23	0.67	0.033	15	**5**	**15**	**5**	**25**	**0.80**	**0.038**	**Postponed until 2/2006**		
13	**99214**		25	13	38	1.10	0.032	25	**5**	**25**	**10**	**40**	**1.30**	**0.039**	**Postponed until 2/2006**		
14	**99215**		40	19	59	1.77	0.034	40	**8**	**35**	**15**	**58**	**2.00**	**0.042**	**Postponed until 2/2006**		
15	**Initial hospital**																
16	**99221**		30		43	1.28	0.033	30	**10**	**30**	**13**	**53**	**1.88**	**0.045**	**1.88**	**0.045**	
17	**99222**		50		71	2.14	0.033	50	**15**	**40**	**20**	**75**	**2.56**	**0.044**	**2.56**	**0.044**	Interim
18	**99223**	10	45	50	105	2.99	0.037	70	**20**	**55**	**25**	**100**	**3.78**	**0.050**	**3.78**	**0.050**	Interim
19	**Subsequent hosp**																
20	**99231**		15	4	19	0.64	0.037	15	**5**	**15**	**5**	**25**	**0.76**	**0.036**	**0.76**	**0.036**	
21	**99232**		25	5	30	1.06	0.038	25	**10**	**20**	**10**	**40**	**1.30**	**0.043**	**1.30**	**0.043**	Interim
22	**99233**		35	6	41	1.51	0.039	35	**10**	**25**	**15**	**50**	**2.00**	**0.058**	**2.00**	**0.058**	Interim

	A	B	C	D	E	F	G	I	J	K	L	M	N	O	AF	AG	AH
1		Existing Data - RUC database						CPT	Workgroup Recommendations						RUC Recommendations		
2	Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Calc IWPUT	Time	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	IWPUT	Work RVU	IWPUT	
23	**Hosp discharge**																
24	**99238**	6	18	12	36	1.28	0.049	) or le	**9**	**20**	**10**	**39**	**1.28**	**0.043**	**1.28**	**0.043**	
25	**99239**	9	20	16	45	1.75	0.060	re tha	**10**	**30**	**15**	**55**	**1.90**	**0.045**	**1.90**	**0.045**	
26	**Office consult**																
27	**99241**		15		23	0.64	0.031	15	**5**	**15**	**5**	**25**	**0.64**	**0.028**	**0.64**	**0.028**	
28	**99242**		30		45	1.29	0.032	30	**5**	**25**	**10**	**40**	**1.34**	**0.040**	**1.34**	**0.040**	
29	**99243**	5	30	31	66	1.72	0.030	40	**10**	**35**	**10**	**55**	**1.97**	**0.043**	**1.88**	**0.041**	
30	**99244**		60		88	2.58	0.033	60	**10**	**45**	**15**	**70**	**3.02**	**0.055**	**3.02**	**0.055**	
31	**99245**	10	48	50	108	3.42	0.043	80	**15**	**60**	**20**	**95**	**3.77**	**0.050**	**3.77**	**0.050**	
32	**Inpatient consult**																
33	**99251**		20		26	0.66	0.026	20	**5**	**20**	**5**	**30**	**1.00**	**0.039**	**1.00**	**0.039**	
34	**99252**		32		42	1.32	0.034	40	**5**	**35**	**10**	**50**	**1.50**	**0.033**	**1.50**	**0.033**	
35	**99253**	10	30	35	75	1.82	0.027	55	**10**	**40**	**15**	**65**	**2.27**	**0.043**	**2.27**	**0.043**	
36	**99254**		65		84	2.64	0.034	80	**15**	**50**	**20**	**85**	**3.29**	**0.050**	**3.29**	**0.050**	
37	**99255**	15	45	57	117	3.64	0.045	110	**20**	**60**	**25**	**105**	**4.00**	**0.050**	**4.00**	**0.050**	
38	**Emergency visit**																
39	**99281**		10		11	0.33	0.031	N/A	**2**	**7**	**4**	**13**	**0.33**	**0.028**	**0.45**	**0.045**	
40	**99282**		15		16	0.55	0.035	N/A	**3**	**10**	**5**	**18**	**0.55**	**0.037**	**0.88**	**0.070**	
41	**99283**		25		26	1.24	0.049	N/A	**5**	**18**	**7**	**30**	**1.24**	**0.054**	**1.34**	**0.060**	
42	**99284**		40		42	1.95	0.048	N/A	**5**	**25**	**10**	**40**	**1.95**	**0.065**	**2.56**	**0.089**	
43	**99285**		50		53	3.06	0.061	N/A	**8**	**40**	**15**	**63**	**3.06**	**0.064**	**3.80**	**0.082**	

	A	B	C	D	E	F	G	I	J	K	L	M	N	O	AF	AG	AH
1		Existing Data - RUC database						CPT	Workgroup Recommendations						RUC Recommendations		
2	Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Calc IWPUT	Time	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	IWPUT	Work RVU	IWPUT	
44	Critical care																
45	99291	15	45	15	75	3.99	0.074	30–74	15	40	20	75	4.29	0.088	4.29	0.088	Interim
46	99292		30		30	2.00	0.067	h addl 30		30		30	2.15	0.072	2.15	0.072	Interim
47																	
48	Reference Codes																
49	45340	17	25	16	58	1.89	0.046										
50	60100	15	25	10	50	1.56	0.040										
51	76005	10	20	5	35	0.60	0.013										
52	90801	10	60	55	125	2.80	0.022										
53	90847	5	50	21	76	2.21	0.033										
54	90880	8	50	40	98	2.19	0.022										
55	93503	20	30	45	95	2.91	0.048										
56	95810	15	60	20	95	3.52	0.046										
57	95903	8	10	10	28	0.60	0.020										
58	97110	2	14	2	18	0.45	0.026										
59	99217	10	30	15	55	1.28	0.024										
60	99234	10	60	15	85	2.56	0.033										
61	99235	10	75	15	100	3.41	0.038										
62	99236				110	4.26											
63	99299	10	30	15	55	2.50	0.065										

	A	B	C	D	E	F	G	I	J	K	L	M	N	O	AF	AG	AH
1		Existing Data - RUC database						CPT	Workgroup Recommendations						RUC Recommendations		
2	Code	Pre-Time	Intra Time	Post Time	Total Time	Current RVW	Calc IWPUT	Time	Pre-Time	Intra-Time	Post-Time	Total Time	Work RVU	IWPUT	Work RVU	IWPUT	
64	**Reference Codes**																
65	99341	6.5	20	10	36.5	1.01	0.032										
66	99342	10	30	12	52	1.52	0.034										
67	99343	15	50	17	82	2.27	0.031										
68	99344	15	60	25	100	3.03	0.036										
69	99345	15	90	30	135	3.78	0.031										
70	99347	5	15	10	30	0.76	0.028										
71	99348	9	30	10	49	1.26	0.028										
72	99349	10	40	15	65	2.02	0.037										
73	99350	15	72	20	107	3.03	0.031										
74	99375	10	32	15	57	1.73	0.037										
75	99386	5	40	10	55	1.88	0.039										
76	99387	5	45	10	60	2.06	0.038										
77	99396	5	30	10	45	1.53	0.040										
78	99433	3	15	2	20	0.62	0.034										

201	Total	AAD	AAFP	AACE	ACP	ANA	AOA	SGIM	APMA	Other	Typical Vignette Yes	Typical Vignette No
Typical vignette?											207	37
Yes	85%	12	17	30	36	18	20	29	31	14		
No	15%	1	3	9	6	4	2	6	3	3		
Total	**100%**	**13**	**20**	**39**	**42**	**22**	**22**	**35**	**34**	**17**		
Q2 Physician time for surveyed code												
Pre-service time												
Low	1 0	1 0	1 0	1.0	1 0	1 0	1 0	1 0	2 0	1 0	1.0	1.0
25th Percentile	2 0	2 0	1 0	4 0	1.0	2 0	2 0	2 0	3 0	5 0	2.0	2.0
Median	3 0	3 0	2 0	5 0	2 0	3 0	2 5	3 0	5 0	5 0	3.0	5.0
75th Percentile	5 0	5 0	5 0	6 3	5 0	5 0	5 0	5 0	5 0	5.0	5.0	5.0
High	30 0	10 0	10 0	30 0	10 0	30 0	5 0	10 0	10 0	10 0	30.0	10.0
Intra-service time												
Low	3 0	10 0	5 0	5 0	3 0	5 0	5 0	5 0	5 0	10 0	3.0	4.0
25th Percentile	8.0	15 0	7 0	5 0	6 0	7 8	10 0	10 0	7 3	10 0	9.0	5.0
Median	10 0	20 0	10 0	10 0	10 0	10 0	10 0	10 0	10 0	10 0	10.0	9.0
75th Percentile	15 0	20 0	10 0	11 3	10 0	12 3	15 0	12 5	15 0	20 0	15.0	10.0
High	60 0	25 0	15 0	60 0	20 0	30 0	25 0	30 0	25 0	20 0	30.0	30.0
Post-service time												
Low	1.0	2 0	1 0	1 0	1 0	2 0	1 0	1 0	2 0	5 0	1.0	1.0
25th Percentile	2 0	2 0	3 5	5 0	2 0	2 8	2 0	3 0	2 8	5 0	2.0	2.8
Median	5 0	3 0	5 0	5 0	3 0	4 5	5 0	5 0	5 0	5 0	5.0	5.0
75th Percentile	5 0	5 0	10 0	5 0	5 0	6 3	6 0	10 0	5 5	5 0	5.0	6.3
High	30 0	10 0	10 0	30 0	10 0	25 0	15 0	20 0	11 0	10 0	25.0	15.0
Q8 Estimated Work RVU for CPT code												
Low	0 15	0 90	0 17	0 20	0 17	0 17	0 34	0 15	0 47	0 90	0.15	0.17
25th Percentile	0 60	0 95	0 38	0 40	0 45	0 68	0 58	0 50	0 94	1 35	0.58	0.79
Median	0 98	1 00	0 75	1 25	0 76	0 98	0 98	0 78	1 02	1 50	0.95	1.09
75th Percentile	1 20	1 20	1 00	1.88	1 00	1 36	1 09	1 00	1 29	3 63	1.05	1.30
High	30 00	2 99	1 50	2 00	1.28	30 00	2 06	2 00	7 00	10 00	30.00	1.50

202	Total	AAD	AAFP	AACE	ACP	ANA	AOA	SGIM	APMA	Other	Typical Vignette Yes	Typical Vignette No
Typical vignette?											214	31
Yes	87%	12	17	30	38	20	22	29	32	14		
No	13%	1	3	9	5	2		6	2	3		
Total	**100%**	**13**	**20**	**39**	**43**	**22**	**22**	**35**	**34**	**17**		
Q2 Physician time for surveyed code												
Pre-service time												
Low	1 0	1 0	1.0	1 0	1 0	2 0	1 0	1 0	2 0	2 0	1.0	1.0
25th Percentile	2 0	2.0	1.3	2.0	1 0	3 0	3 0	2.0	5 0	5.0	2.0	2.0
Median	5.0	3.0	2.0	5.0	2 0	3 5	5.0	5 0	5.0	5.0	5.0	5.0
75th Percentile	5 0	5.0	5 0	10 0	5.0	5.0	5.0	5 0	10.0	5.5	5.0	10.0
High	40 0	10 0	10.0	40.0	15.0	30.0	10 0	10 0	15 0	10 0	30.0	10.0
Intra-service time												
Low	5.0	10.0	8.0	5.0	5 0	10.0	7 0	7.0	6 0	10.0	5.0	5.0
25th Percentile	14.0	15.0	14.3	10 0	10 0	15.0	15.0	15 0	15 0	15 0	15.0	10.0
Median	15 0	20.0	15 0	15 0	15.0	20.0	20.0	15 0	20.0	15.0	15.0	15.0
75th Percentile	20 0	20.0	15 0	20 0	20.0	20.0	20 0	20 0	20 0	25.0	20.0	15.0
High	75 0	25 0	20.0	75 0	25 0	30.0	30.0	30.0	35 0	30.0	35.0	30.0
Post-service time												
Low	1.0	2.0	1.0	2.0	1.0	2.0	2.0	2 0	3 0	5.0	1.0	2.0
25th Percentile	5.0	2 0	2 5	5 0	2.3	3 0	5.0	5.0	5.0	5 0	5.0	4.8
Median	5 0	3 0	5 0	5 0	5.0	5 0	5.0	5 0	5.0	10.0	5.0	6.5
75th Percentile	10 0	5.0	10.0	8 5	5 0	5 0	8 5	10 0	10 0	10 0	10.0	10.0
High	40.0	10.0	15.0	40 0	15 0	30.0	20 0	20.0	20 0	15.0	30.0	15.0
Q8 Estimated Work RVU for CPT code												
Low	0 30	0.90	0.30	0.50	0 45	0 76	0.45	0 70	0 80	1 01	0.30	0.8
25th Percentile	0.97	0.95	0.98	0.76	0.88	1.00	0 95	0.95	1 25	1.57	0.95	1.1
Median	1.36	1 00	1.25	1.53	1.00	1.50	1.50	1.10	2.00	1.88	1.30	2
75th Percentile	2 00	1.20	1.40	1 95	1.50	1.88	2.00	1 50	2.28	5.25	1.95	2.2
High	30.00	2.99	2 20	3 00	2.40	30 00	3.00	3.03	10.00	15 00	30.00	3.03

203	Total	AAFP	AACE	ACP	ANA	AOA	SGIM	APMA	Other	Typical Vignette Yes	Typical Vignette No
Typical vignette?										185	35
Yes	84%	18	30	39	20	19	27	18	14		
No	16%	2	10	4	2	3	9	2	3		
Total	**100%**	**20**	**40**	**43**	**22**	**22**	**36**	**20**	**17**		
Q2 Physician time for surveyed code											
Pre-service time											
Low	1 0	2 0	2 0	1 0	1 0	2 0	1.0	2.0	2 0	1.0	2.0
25th Percentile	4.0	3.0	5 0	2 0	4 0	5.0	5.0	5.0	5 0	3.3	5.0
Median	5.0	5 0	7.5	5.0	4.0	5.0	5 0	5.0	5.0	5.0	5.0
75th Percentile	7 0	7.0	10.0	5 0	5.0	5 0	5 0	10.0	10.0	6.8	5.0
High	45.0	15 0	45 0	20 0	30.0	10 0	15.0	15 0	15 0	30.0	15.0
Intra-service time											
Low	6 0	15.0	15.0	6.0	12 0	8.0	10 0	15.0	15.0	8.0	6.0
25th Percentile	20 0	20 0	15.0	15.0	22.0	20.0	20 0	15.0	15.0	20.0	15.0
Median	25 0	20.0	20 0	20 0	30.0	30 0	25.0	20.0	20 0	24.0	25.0
75th Percentile	30.0	28.3	26 3	30 0	30 0	30.0	30 0	25.0	25 0	30.0	30.0
High	90 0	40 0	90.0	30.0	45.0	40.0	45 0	30.0	30.0	45.0	40.0
Post-service time											
Low	2.0	2.0	5.0	2 0	2 0	4 0	3.0	5 0	5 0	2.0	2.0
25th Percentile	5 0	5 0	7.3	5 0	5 0	5 0	6 5	5.0	5 0	5.0	5.0
Median	10.0	5 0	10.0	8.0	5.0	10.0	10 0	10.0	10.0	10.0	8.5
75th Percentile	10.0	8.8	10 0	10 0	15.0	10 0	15 0	10.0	10.0	10.0	15.0
High	45.0	20.0	45 0	20.0	35 0	25 0	30.0	15 0	15 0	35.0	20.0
Q8 Estimated Work RVU for CPT code											
Low	0.95	0.95	1.60	1 00	1 01	1.01	1.00	1 00	1.88	0.95	1.00
25th Percentile	1 49	1.30	1.64	1.12	1.53	1.55	1 30	2.44	1 97	1.46	1.57
Median	1 92	1 80	1.88	2.00	1 88	1.88	1 60	2.83	2 25	1.88	2.00
75th Percentile	2 33	2.00	2 23	2.20	2.00	2 00	2.30	3.23	8.13	2.27	2.61
High	45.00	3.00	4.00	3 41	45.00	4.00	4.00	15 00	25 00	45.00	4.00

99204	Total	AAFP	AACE	ACP	ANA	AOA	SGIM	APMA	Other	Typical Vignette Yes	Typical Vignette No
Typical vignette?										181	41
Yes	82%	18	28	34	20	19	31	17	14		
No	18%	2	14	9	2	3	5	3	3		
Total	**100%**	**20**	**42**	**43**	**22**	**22**	**36**	**20**	**17**		
Q2 Physician time for surveyed code											
Pre-service time											
Low	1 0	2 0	4.0	1.0	2.0	4 0	1 0	5.0	5.0	1.0	1.0
25th Percentile	5 0	4 5	5.0	4 0	5 0	5.0	5 0	6 3	5 0	5.0	5.0
Median	5 0	5.0	10 0	5.0	7.0	5 0	8.0	10.0	10.0	6.5	5.0
75th Percentile	10 0	10.0	15.0	5.0	8.0	10.0	10.0	13 8	10 0	10.0	10.0
High	45 0	15.0	45.0	25.0	30 0	15 0	20.0	15.0	20 0	45.0	20.0
Intra-service time											
Low	10 0	15.0	20.0	10.0	25 0	12.0	20.0	20.0	25.0	12.0	10.0
25th Percentile	30 0	30.0	23.8	25 0	32.5	30 0	30.0	25 0	30.0	30.0	30.0
Median	40 0	30 0	35.0	35.0	45.0	45 0	40.0	30.0	35 0	40.0	35.0
75th Percentile	45 0	40.0	45.0	45.0	45.0	45 0	45.0	35.0	40 0	45.0	40.0
High	120 0	50 0	120.0	60.0	60 0	60 0	60.0	45.0	45 0	120.0	60.0
Post-service time											
Low	2 0	5.0	5.0	2.0	5 0	5.0	5.0	5 0	5.0	5.0	2.0
25th Percentile	10 0	10 0	10.0	8.0	10.0	10.0	10.0	10 0	10.0	10.0	10.0
Median	12 0	10 0	15.0	10.0	12.5	10 0	15.0	10.0	15 0	10.0	13.5
75th Percentile	20.0	13 8	15.0	15.0	20.0	15 0	21 3	13.8	20 0	20.0	18.8
High	60.0	30 0	45.0	25 0	30 0	35.0	60 0	20.0	30.0	60.0	30.0
Q8 Estimated Work RVU for CPT code											
Low	1 00	1 53	1.80	1.00	1.60	1 50	1.50	3 03	2 10	1.00	1.80
25th Percentile	2.03	2.35	2 13	2 00	2 02	2 21	1 93	3.60	2 21	2.02	2.50
Median	2 78	2 50	2 50	2 90	2 75	2 53	2 75	3.80	2.63	2.66	3.00
75th Percentile	3 44	3.00	2.73	3.13	3 76	3.42	3 35	4.23	9.75	3.46	3.40
High	60 00	3 70	5 00	4.00	60.00	6.00	5.30	20 00	30 00	60.00	4.30

205	Total	AAFP	AACE	ACP	ANA	AOA	SGIM	APMA	Other	Typical Vignette Yes	Typical Vignette No
Typical vignette?										192	29
Yes	87%	18	37	36	19	21	31	16	14		
No	13%	2	6	6	3	1	5	3	3		
Total	**100%**	**20**	**43**	**42**	**22**	**22**	**36**	**19**	**17**		
Q2 Physician time for surveyed code											
Pre-service time											
Low	1.0	5 0	10 0	1 0	2 0	5 0	1.0	5 0	5 0	1.0	1.0
25th Percentile	5 0	5 0	10.0	5.0	7.0	5 0	5.0	10 0	8.8	5.0	5.0
Median	10 0	10.0	10 0	5.0	9.0	5.5	10.0	12 5	10.0	10.0	7.0
75th Percentile	15.0	10 0	16 3	8.0	10 0	11 3	15.0	15.0	11 3	15.0	10.0
High	45.0	20 0	45.0	25 0	30 0	20 0	25 0	30 0	20 0	45.0	30.0
Intra-service time											
Low	20.0	25.0	35 0	25.0	30.0	20.0	30.0	30.0	30.0	20.0	30.0
25th Percentile	40 0	30 0	38.8	40.0	52 5	40.0	45 0	31 3	40 0	40.0	41.3
Median	50 0	35.0	47.5	50.0	60 0	60 0	47 5	40 0	45.0	50.0	50.0
75th Percentile	60 0	40.0	60 0	60.0	60.0	60.0	60.0	48.8	45.0	60.0	60.0
High	180.0	45 0	180 0	120.0	90.0	90.0	60.0	60.0	60.0	180.0	65.0
Post-service time											
Low	2 0	5 0	10.0	2 0	10 0	5 0	5.0	5 0	10 0	5.0	2.0
25th Percentile	15.0	10 0	15.0	11 3	17.5	14.3	15.0	11.3	15.0	15.0	11.3
Median	15.0	15 0	20 0	15.0	20 0	15.0	20 0	17.5	15.0	18.0	15.0
75th Percentile	28 8	20 0	22.5	20.0	27 5	21.3	30 0	27.5	20 0	30.0	20.0
High	90 0	30.0	45.0	60 0	60.0	45 0	90.0	30 0	60 0	90.0	60.0
Q8 Estimated Work RVU for CPT code											
Low	1.50	1.71	2.00	1 50	1.80	1 50	1.50	3 78	2 75	1.50	2.90
25th Percentile	3 00	3.13	2.25	3 00	3 03	3 01	2 50	4.08	3 15	3.00	3.59
Median	3.78	3 50	3.50	3.64	4.00	3.64	3.50	4.80	3.69	3.78	4.00
75th Percentile	4.38	4 26	4.00	4.44	4.50	4 28	4 20	5.00	3.95	4.50	4.27
High	60 00	4.50	6.00	8.52	60 00	5.20	6 80	27.00	45 00	60.00	4.60

211	Total	AAFP	ACP	AAN	ACR	SGIM	ANA	ASCO	AOA	TES	OTHER	Typical Vignette YES	Typical Vignette NO
Typical vignette?												194	30
Yes	87%	6	23	12	12	23	9	1	21	73	14		
No	13%	1	4	7	4	2				11	1		
Total	**100%**	**7**	**27**	**19**	**16**	**25**	**9**	**1**	**21**	**84**	**15**		
Q2 Physician time for surveyed code													
Pre-service time													
Low	1.0	5.0	1.0	1 0	1.0	1.0	1.0	na	1 0	1.0	1 0	1.0	2.0
25th Percentile	1.0	5.0	1 0	1.5	1.0	1.0	1 3	na	1.0	2.0	1.0	1.0	5.0
Median	2 0	5.0	2.0	3 0	1 5	1 0	2 5	na	1 0	4.0	2 0	2.0	5.0
75th Percentile	5 0	5.0	5 0	5 0	2 0	3.5	4.5	na	3.5	5 0	4 0	5.0	5.0
High	15 0	5 0	5.0	5.0	3.0	5.0	5.0	na	5 0	15 0	5.0	15.0	5.0
Intra-service time													
Low	1.0	3.0	3 0	2.0	1.0	2 0	2 0	3 0	2 0	1.0	2.0	1.0	1.0
25th Percentile	3 0	4.0	4 0	5 0	2 0	2 8	4 3	3 0	2.8	5 0	2 3	3.0	7.5
Median	5.0	5.0	5.0	5 0	5.0	5.0	5 0	3.0	5 0	5 0	5 0	5.0	10.0
75th Percentile	5.0	5.0	5.0	10.0	5.0	5.0	5.0	3 0	5 0	9.0	5.8	5.0	15.0
High	20.0	5.0	10 0	20 0	5.0	10.0	10 0	3.0	10 0	20.0	15.0	20.0	20.0
Post-service time													
Low	1 0	1 0	1.0	1 0	1 0	1 0	2.0	7.0	1 0	1 0	2 0	1.0	5.0
25th Percentile	2.0	2 0	2 0	3.0	1.8	1.0	2.8	7.0	1 0	4 5	2 5	2.0	5.0
Median	3 0	3.0	2.0	4 0	2 5	2.0	4 0	7 0	2 0	5.0	5.0	3.0	5.0
75th Percentile	5 0	4 0	5.0	5 0	4 3	5 0	5 0	7.0	5.0	6 3	5.0	5.0	5.0
High	20.0	5 0	10.0	10 0	5 0	15 0	5.0	7.0	15 0	20 0	7 0	20.0	10.0
Q8 Estimated Work RVU for CPT code													
Low	0.15	0.17	0.17	0 17	0.17	0.15	0.17	na	0.17	0 17	0 20	0.15	0.17
25th Percentile	0.18	0 20	0.17	0 17	0 23	0 20	0.21	na	0 19	0 33	0 36	0.17	0.33
Median	0 38	0.29	0 25	0.40	0 38	0 35	0 35	na	0 60	0.58	0.73	0.38	0.55
75th Percentile	0 75	0.66	0.50	0.50	0.50	0.50	0 40	na	1.00	1.50	0 94	0.75	1.00
High	15 00	1.00	1 00	1.00	0 80	1 20	0.50	na	2.00	2 00	15 00	15.00	1.20

RVS Update Survey
July 8, 2005

99212	Total	AAFP	ACP	ANA	AOA	AAN	ACR	SGIM	ASCO	OTHER	TES	Typical Vignette YES	Typical Vignette NO
ɔical vignette?												184	39
Yes	83%	5	21	9	17	13	15	23		12	69		
No	17%	2	6		4	6	1	2	1	3	14		
Total	**100%**	**7**	**27**	**9**	**21**	**19**	**16**	**25**	**1**	**15**	**83**		
Q2 Physician time for surveyed code													
Pre-service time													
Low	0 5	2 0	1 0	2 0	1 0	2 0	2 0	0 5	5 0	1 0	1 0	0.5	1.0
25th Percentile	2 0	2 5	1 3	2 0	2 0	5 0	2 0	1 0	5 0	1.0	2 0	2.0	2.0
Median	3 0	3 0	2 5	5 0	2 0	5 0	2 0	2 0	5 0	2 0	4 5	3.0	5.0
75th Percentile	5 0	4 0	5 0	5 0	5 0	5 0	3 0	3 0	5 0	3 5	5 0	5.0	5.0
High	20 0	5 0	10 0	5 0	7 0	5 0	5 0	5 0	5 0	5 0	20 0	10.0	5.0
Intra-service time													
Low	2 0	5 0	5 0	5 0	5 0	5.0	4 0	5 0	7 0	2 0	2 0	2.0	2.0
25th Percentile	10 0	7 0	9 0	10 0	10 0	10 0	6 0	6 8	7 0	10 0	10 0	10.0	7.0
Median	10 0	10 0	10 0	10 0	10 0	10 0	8 0	10 0	7 0	10 0	10 0	10.0	10.0
75th Percentile	10 0	10 0	10 0	15 0	12 0	12 5	10 0	10 0	7 0	10 0	12 8	10.0	10.0
High	30 0	10 0	20 0	15 0	20 0	25 0	15 0	15 0	7 0	25 0	30 0	25.0	25.0
Post-service time													
Low	1 0	1 0	1 0	3 0	1 0	2 0	1 0	1 0	15 0	2 0	1 0	1.0	2.0
25th Percentile	3 0	2 0	2 0	3 5	2 5	5 0	2 5	2 3	15 0	3 0	3 0	3.0	3.0
Median	5 0	3 0	4 5	5 0	3 0	5 0	3 0	3 0	15 0	5 0	5 0	5.0	5.0
75th Percentile	5 5	4 0	8 8	8 8	5 0	10 0	5 0	5 0	15 0	5 0	10 0	5.0	6.3
High	20 0	5 0	10 0	10 0	8 0	10 0	5 0	15 0	15 0	10.0	20 0	15.0	15.0
Q8 Estimated Work RVU for CPT code													
Low	0 30	0 60	0 38	0 63	0 38	0 60	0.45	0 30	na	0 70	0 45	0.30	0.45
25th Percentile	0 62	0 65	0 51	0 75	0 62	0 65	0 59	0 60	na	0 81	0 89	0.60	0.79
Median	0 95	0 88	0 77	1 06	1 00	0 80	0 85	0 76	na	1 01	1 00	0.95	0.98
75th Percentile	1.30	1 00	1 00	1 36	1 29	0 98	1 34	1 15	na	1 38	1 40	1.27	1.28
High	20 00	1 50	1 71	1 38	2 00	1 05	1 53	2 00	na	20 00	2 00	20.00	2.00

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99213	Total	AAFP	ACP	AAN	ACR	SGIM	ANA	ASCO	AOA	TES	OTHER	Typical Vignette YES	Typical Vignette NO
ypical vignette?												192	44
Yes	81%	6	24	15	14	21	9	5	16	67	15		
No	19%	1	4	5	2	4		6	5	16	1		
Total	**100%**	**7**	**28**	**20**	**16**	**25**	**9**	**11**	**21**	**83**	**16**		
Q2 Physician time for surveyed code													
Pre-service time													
Low	1 0	2 0	1 0	2 0	1 0	1 0	3 0	3 0	1 0	1 0	2 0	1.0	1.0
25th Percentile	3 0	2 8	2 0	5 0	2 5	2 0	3 5	5 0	2 5	3 0	3 0	3.0	3.0
Median	5 0	4 0	5 0	5 0	3 0	5 0	5 0	5 0	5 0	5 0	3 0	5.0	5.0
75th Percentile	5 0	6 3	5 0	7 5	4 5	5 0	5.0	6 0	5 0	5 0	5 0	5.0	5.0
High	25 0	10 0	10 0	10 0	5 0	10 0	5 0	20 0	10 0	25 0	10 0	15.0	20.0
Intra-service time													
Low	8 0	10 0	8 0	15 0	8 0	10 0	12 0	12 0	10 0	10 0	10 0	8.0	8.0
25th Percentile	15 0	12 0	14 3	15 0	10 0	14 0	15 0	13 0	15 0	15 0	15 0	15.0	14.3
Median	15 0	15 0	15 0	15 0	14 0	15 0	15 0	15 0	15 0	15 0	15 0	15.0	15.0
75th Percentile	20 0	15 0	20 0	20 0	15 0	15 0	20 0	15 0	17 5	20.0	15.0	17.5	20.0
High	40 0	20 0	30 0	30 0	25 0	20 0	30 0	30 0	30 0	40 0	30 0	30.0	30.0
Post-service time													
Low	1 0	1 0	2 0	5 0	2 0	2 0	5 0	3 0	3 0	3 0	2 0	1.0	2.0
25th Percentile	5 0	2 5	5 0	6 5	5 0	4 0	5 0	5 0	5 0	5 0	4 3	5.0	5.0
Median	5 0	4 0	5 5	10 0	5 0	5 0	6 5	7 0	5 0	10 0	5 0	5.0	10.0
75th Percentile	10 0	6 3	10 0	11 3	5 0	13 8	10 5	21 0	9 3	12 8	7 0	10.0	15.0
High	30 0	10 0	15 0	15 0	10 0	20 0	15 0	30 0	12 0	30 0	10 0	30.0	30.0
Q8 Estimated Work RVU for CPT code													
Low	0 50	0 95	0 67	1 00	0 67	0 50	1 53	0 85	0 76	0 72	1 00	0.50	0.76
25th Percentile	1 00	0 95	1 01	1 36	1 00	0 93	1.88	1 10	1 10	1 01	1 40	1.00	1.00
Median	1 40	0 95	1 27	1 46	1 29	1 01	2 01	1 75	1 35	1 45	1 53	1.45	1.33
75th Percentile	1 72	1 03	1.65	1 50	1 65	1 48	2 20	2 28	1 80	1.55	1 60	1.71	2.00
High	30 00	1 10	3 00	3 00	2 12	2 75	2 72	3 40	3 50	30 00	2 00	30.00	3.40

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99214	Total	AAFP	ACP	AAN	ACR	SGIM	ANA	ASCO	AOA	TES	OTHER	Typical Vignette YES	Typical Vignette NO
ypical vignette?												189	51
Yes	79%	6	25	11	15	19	9	6	18	65	15		
No	21%	1	3	10	1	6		5	4	20	1		
Total	**100%**	**7**	**28**	**21**	**16**	**25**	**9**	**11**	**22**	**85**	**16**		
Q2 Physician time for surveyed code													
Pre-service time													
Low	1 0	3 0	2 0	1 0	1 0	2 0	3 0	3 0	2 0	2 0	2 0	1.0	2.0
25th Percentile	5 0	3 8	5 0	5 0	3 0	5 0	5 0	5 0	3 0	5 0	2 5	5.0	4.5
Median	5 0	4 5	5 0	5 0	5 0	5 0	5 0	7 0	5 0	5 0	5 0	5.0	5.0
75th Percentile	10 0	5 0	8 5	10 0	5 0	9 0	5 0	10 0	6 0	10	6 5	10.0	8.5
High	30 0	5 0	15 0	12 0	10 0	10 0	7 0	30 0	10 0	25 0	15 0	30.0	30.0
Intra-service time													
Low	9 0	15 0	12 0	18 0	9 0	15 0	20 0	15 0	15 0	15 0	15 0	9.0	15.0
25th Percentile	20 0	15 0	20 0	20 0	15 0	20 0	25 0	20 0	21 3	20 0	16 3	20.0	20.0
Median	25 0	17 5	25 0	25 0	20 0	25 0	27 5	25 0	25 0	25 0	22 5	25.0	25.0
75th Percentile	30 0	21 3	30 0	30 0	25 0	26 3	37 5	30 0	30 0	30	28 8	30.0	30.0
High	60 0	25 0	45 0	35 0	30 0	45 0	45 0	60 0	45 0	60 0	30 0	60.0	40.0
Post-service time													
Low	3 0	5 0	3 0	4 0	3 0	5 0	10 0	8 0	3 0	4 0	5 0	3.0	4.0
25th Percentile	8 0	6 5	7 8	10 0	5 0	6 8	10 0	10 0	7 0	10 0	7 8	7.3	8.0
Median	10 0	7 5	10 0	15 0	7 0	10 0	10 0	10 0	10 0	10 0	10 0	10.0	10.0
75th Percentile	15 0	8 5	18 8	15 0	10 0	15 0	13 8	25 0	12 5	15 0	22 5	15.0	16.3
High	60 0	10 0	20 0	23 0	15 0	45 0	20 0	60 0	15 0	40 0	30 0	60.0	40.0
Q8 Estimated Work RVU for CPT code													
Low	0 85	1 20	1 10	1 00	1 30	0 85	1 71	2 00	1 00	1 14	1 10	1.00	0.85
25th Percentile	1 53	1 35	1 50	1 61	1 55	1 64	2 35	2 11	1 57	1 58	1 53	1.51	1.70
Median	2 00	1 50	2 00	1 76	1 75	2 00	2 78	2 34	1 80	1 95	2 00	2.00	1.85
75th Percentile	2 50	1 52	2 55	1 91	2 72	2 08	3 01	2 85	2 61	2 13	2 90	2.50	2.15
High	45 00	1 53	3 41	3 50	24 00	3 50	3 03	4 30	4 50	45 00	3 00	45.00	4.50

99215	Total	AAFP	ACP	AAN	ACR	SGIM	ANA	ASCO	AOA	TES	OTHER	Typical Vignette YES	Typical Vignette NO
Typical vignette?												186	42
Yes	82%	6	23	14	13	23	9	2	19	67	10		
No	18%	1	5	6	3	2			3	18	4		
Total	**100%**	**7**	**28**	**20**	**16**	**25**	**9**	**2**	**22**	**85**	**14**		
Q2 Physician time for surveyed code													
Pre-service time													
Low	1 0	5 0	2 0	2 0	1 0	3 0	5 0	5 0	2 0	2 0	2 0	2.0	1.0
25th Percentile	5 0	5 0	5 0	5 0	4 3	5 0	5 0	6 8	5 0	5 0	4 0	5.0	5.0
Median	7 5	5 0	7 0	10 0	5 0	10 0	5 0	8 5	7 0	10 0	5 0	7.5	7.5
75th Percentile	10.0	6 3	10 0	10 5	10 0	10 0	5 0	10 3	10 0	15 0	10 0	10.0	10.0
High	30 0	10 0	20 0	20 0	20 0	10 0	7 0	12 0	15 0	30 0	15 0	20.0	25.0
Intra-service time													
Low	12 0	15 0	25 0	19 0	12 0	20 0	25 0	40 0	20 0	20 0	20 0	12.0	25.0
25th Percentile	30 0	17 3	30 0	30 0	19 3	30 0	33 8	41 3	30 0	30 0	27 5	30.0	30.0
Median	35 0	24 0	37 5	32 5	30 0	40 0	45 0	42 5	35 0	40 0	40 0	35.0	35.0
75th Percentile	45 0	31 3	45 0	43 8	32 5	41 3	48 8	43 8	45 0	45 0	47 5	45.0	45.0
High	60 0	35 0	60 0	45 0	60 0	60 0	60 0	45 0	60 0	60 0	60 0	60.0	60.0
Post-service time													
Low	3 0	10 0	5 0	8 0	5 0	5 0	10 0	15 0	3 0	5 0	10 0	3.0	5.0
25th Percentile	10 0	10 0	10 0	12 8	5 0	13 8	11 3	22 5	10 0	12 0	10 0	10.0	10.0
Median	15 0	10 0	12 0	15 0	10 0	17 5	15 0	30 0	15 0	15 0	16 5	15.0	15.0
75th Percentile	20 0	11 3	20 0	20 0	18 8	20 0	26 3	37 5	16 3	20 0	26 0	20.0	30.0
High	60 0	15 0	30 0	30 0	45 0	60 0	30 0	45 0	60 0	60 0	30 0	60.0	30.0
Q8 Estimated Work RVU for CPT code													
Low	1 00	1 70	1 40	1 00	1 70	1 20	2 06	3 00	1.00	1 50	1 50	1.00	1.00
25th Percentile	2 00	1 86	2 00	1 88	2 05	2 03	2 79	3 00	2 05	2 00	1 53	2.00	2.27
Median	2 70	2 02	3 00	2 00	2 24	2 95	3 23	3 00	2 60	2 55	2 56	2.56	2.70
75th Percentile	3 30	2 51	4 00	2 75	3 31	3 00	3 82	3 00	3 31	3 15	4 00	3.40	3.03
High	60 00	3 00	4 49	4 50	5 10	5 00	5 00	3 00	5 90	60 00	4 00	60.00	4.26

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99221	Total	AAFP	AAN	ACP	AOA	SGIM	SHM	OTHER	Typ Vignette YES	Typ Vignette NO
Typical vignette?									44	20
Yes	68.8%	10 0	6 0	10 0	1 0	8 0	7 0	2 0		
No	31 3%	1 0	6 0	8 0	1 0	3 0	1 0	0 0		
Total	**100.0%**	**11.0**	**12.0**	**18.0**	**2.0**	**11.0**	**8.0**	**2.0**		
Q2 Physician time for surveyed code										
Pre-service time										
Low	2 0	2 0	5.0	2 0	10.0	2.0	5.0	10.0	2.0	2.0
25th Percentile	5.0	5.5	5 0	6.3	12 5	5.0	10.0	10.0	5.0	10.0
Median	10 0	10.0	7 5	10.0	15.0	5.0	12 5	10 0	10.0	15.0
75th Percentile	15.0	15.0	17 5	15.0	17 5	12 5	16 3	10 0	15.0	20.0
High	45.0	40 0	30.0	40 0	20 0	20 0	20.0	10 0	30.0	45.0
Intra-service time										
Low	10 0	15 0	15.0	10.0	30.0	15.0	20.0	20.0	10.0	15.0
25th Percentile	20 0	20.0	20.0	20.0	30.0	20.0	27.5	22 5	20.0	20.0
Median	30 0	30.0	30.0	30.0	30.0	30.0	30.0	25.0	30.0	30.0
75th Percentile	30.0	40 0	43.8	40.0	30.0	30 0	30 0	27.5	30.0	40.0
High	60.0	60 0	45.0	60.0	30.0	45 0	30 0	30 0	60.0	45.0
Post-service time										
Low	3 0	3.0	5 0	3 0	10.0	5.0	10.0	5.0	3.0	3.0
25th Percentile	10.0	10.0	10 0	10.0	11 3	10.0	10 0	6 3	10.0	12.5
Median	12.5	10.0	15 0	15.0	12 5	10.0	10.0	7 5	10.0	15.0
75th Percentile	18.8	15 0	30.0	15 0	13 8	17.5	15.0	8 8	15.0	25.0
High	60 0	40 0	30.0	40.0	15 0	30 0	15.0	10 0	30.0	60.0
Q8 Estimated Work RVU for CPT code										
Low	0 95	1.00	2 00	1 36	2.50	0.95	1 40	2.00	0.95	1.60
25th Percentile	1.88	1 75	2 42	2 00	2 50	1.38	2 00	2 19	1.58	2.34
Median	2.56	2 56	3 00	2 56	2 50	1 60	2.40	2.38	2.48	2.75
75th Percentile	3 00	2 56	3 17	2 60	2 50	2.70	2 56	2 56	2.60	3.21
High	6 00	3.20	5 00	3 41	2 50	6.00	3 00	2.75	3.84	6.00

99222	Total	AAFP	AAN	ACP	AOA	SGIM	SHM	OTHER	Typical Vignette Yes	Typical Vignette No
Typical vignette?									47	16
Yes	75%	10.0	8 0	11.0	2 0	8 0	6.0	2.0		
No	25%	1 0	3 0	7.0	0.0	3.0	2 0	0.0		
Total	**100%**	**11.0**	**11.0**	**18.0**	**2.0**	**11.0**	**8.0**	**2.0**		
Q2 Physician time for surveyed code										
Pre-service time										
Low	4 0	5 0	5 0	5.0	10.0	4 0	5.0	15.0	4.0	10.0
25th Percentile	10.0	7 5	12.5	10 0	12 5	6.5	10.0	15.0	10.0	15.0
Median	15 0	20.0	15 0	15 0	15 0	10 0	15 0	15.0	15.0	20.0
75th Percentile	20.0	32 5	20 0	18.8	17.5	17 5	16 3	15 0	17.5	30.0
High	60.0	35 0	60 0	50.0	20.0	30 0	20.0	15 0	35.0	60.0
Intra-service time										
Low	15 0	25 0	20 0	15 0	40 0	20 0	20 0	20.0	15.0	20.0
25th Percentile	30.0	30.0	30 0	30.0	40.0	30 0	37 5	27 5	30.0	30.0
Median	40.0	35.0	50 0	42.5	40.0	40 0	40.0	35 0	40.0	42.5
75th Percentile	50 0	55 0	60.0	50.0	40.0	50.0	41.3	42 5	50.0	52.5
High	75 0	70 0	70.0	75.0	40.0	60 0	45 0	50.0	75.0	60.0
Post-service time										
Low	5.0	5 0	5 0	10 0	10.0	10 0	15 0	10.0	5.0	10.0
25th Percentile	15 0	10 0	17.5	15.0	12.5	15.0	15.0	11 3	15.0	20.0
Median	20 0	20 0	30.0	20 0	15.0	20.0	20.0	12 5	20.0	27.5
75th Percentile	27.5	20 0	30.0	27.5	17.5	20 0	30.0	13.8	20.0	32.5
High	70.0	35.0	70 0	60 0	20 0	30 0	30 0	15.0	35.0	70.0
Q8 Estimated Work RVU for CPT code										
Low	1 00	1 00	3 03	2 10	3.50	2 00	2.50	3.50	1.00	3.00
25th Percentile	3.00	3.00	3.53	3 00	3.50	2.40	3 02	3.65	2.53	3.32
Median	3.43	3 41	3 83	3 22	3.50	2 60	3 25	3 81	3.41	3.79
75th Percentile	3.80	3 50	4 32	3.70	3.50	3.60	3 65	3 96	3.58	4.00
High	8 50	4.00	7.00	4.00	3 50	8.50	4.26	4.11	7.00	8.50

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99223	Total	AAFP	AAN	ACP	AOA	SGIM	SHM	OTHER	Typical Vignette YES	Typical Vignette NO
pical vignette?									57	8
Yes	88%	9 0	10.0	16 0	2 0	10.0	8.0	2.0		
No	12%	2.0	2.0	3 0	0 0	1 0	0 0	0.0		
Total	**100%**	**11.0**	**12.0**	**19.0**	**2.0**	**11.0**	**8.0**	**2.0**		
Q2 Physician time for surveyed code										
Pre-service time										
Low	5 0	5.0	5 0	10.0	15.0	5 0	10.0	15 0	5.0	15.0
25th Percentile	10.0	15 0	12 5	12.5	16.3	8 0	13.8	16 3	10.0	20.0
Median	20 0	20.0	20 0	15.0	17.5	15.0	20.0	17.5	15.0	25.0
75th Percentile	20 0	35.0	22.5	20.0	18 8	22 5	20.0	18.8	20.0	32.5
High	90 0	40 0	90 0	60 0	20 0	30 0	20.0	20 0	90.0	60.0
Intra-service time										
Low	20 0	30.0	20 0	20.0	50.0	30 0	30.0	20.0	20.0	30.0
25th Percentile	40 0	40 0	50 0	45 0	51.3	42 5	38 8	33 8	40.0	32.5
Median	55.0	50 0	70 0	60 0	52 5	60.0	40 0	47.5	55.0	40.0
75th Percentile	70.0	65.0	75 0	70.0	53.8	65.0	45 0	61.3	70.0	55.0
High	100.0	75 0	90.0	100 0	55 0	75 0	55.0	75.0	100.0	60.0
Post-service time										
Low	5.0	10.0	5 0	15.0	15.0	10 0	15 0	15 0	5.0	20.0
25th Percentile	20 0	17.5	20 0	20.0	18.8	20 0	15.0	18.8	20.0	25.0
Median	25 0	20 0	30.0	25 0	22.5	20 0	25.0	22.5	20.0	30.0
75th Percentile	30.0	30.0	40.0	30.0	26.3	27 5	40.0	26 3	30.0	52.5
High	90.0	40.0	90 0	70.0	30.0	45 0	45 0	30.0	90.0	70.0
Q8 Estimated Work RVU for CPT code										
Low	3.00	3.00	4.00	3 25	4 00	3.00	3.50	4.00	3.00	4.00
25th Percentile	4.00	4 00	4 51	4.00	4.00	3 30	4.13	4 32	4.00	4.07
Median	4 26	4.45	5 00	4.26	4.00	3 70	4 26	4 63	4.26	4.26
75th Percentile	5 00	4 80	5.77	4.44	4 00	4.43	4.63	4.95	5.00	4.82
High	10.00	5 00	9.00	6.50	4.00	10 00	5.33	5 26	10.00	5.00

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99231	Total	AAFP	AAN	ACP	AOA	SGIM	TES	IDSA	OTHER	Typical Vignette YES	Typical Vignette NO
pical vignette?										48	12
Yes	80.0%	5.0	7 0	10 0	4 0	9.0	4 0	3.0	6.0		
No	20 0%	1 0	2 0	5 0	0.0	2.0	0.0	0 0	2.0		
Total	**100.0%**	**6.0**	**9.0**	**15.0**	**4.0**	**11.0**	**4.0**	**3.0**	**8.0**		
Q2 Physician time for surveyed code											
Pre-service time											
Low	2 0	2.0	5 0	2.0	5.0	2.0	5.0	5 0	5.0	2.0	5.0
25th Percentile	5.0	5.0	5 0	5.0	5.0	4.0	5.0	5.0	5 0	5.0	5.0
Median	5.0	5.0	5 0	5.0	7 5	5.0	5 0	5.0	5.0	5.0	5.0
75th Percentile	5.0	6 3	10 5	5 0	10.0	5.0	7.5	5 0	5.0	5.0	13.5
High	20 0	20.0	15 0	20 0	10.0	10.0	10.0	5 0	15.0	10.0	20.0
Intra-service time											
Low	5.0	5.0	5.0	5.0	10 0	5.0	5 0	10.0	10 0	5.0	5.0
25th Percentile	10.0	10 0	10 0	10 0	10.0	9.0	5 0	12.5	10 0	10.0	11.0
Median	15 0	15.0	12 0	15.0	12.5	15.0	7.5	15 0	12.5	10.0	15.0
75th Percentile	15.0	15 0	15 0	20.0	15.0	15 0	11.3	15 0	20.0	15.0	17.5
High	24 0	24.0	20.0	24 0	15.0	15.0	15 0	15.0	20.0	20.0	24.0
Post-service time											
Low	2 0	2 0	5 0	5 0	5 0	2.0	5 0	5 0	5 0	2.0	5.0
25th Percentile	5 0	5.0	5 0	5.0	5.0	5.0	5.0	5 0	5.0	5.0	5.0
Median	5.0	5.0	5 0	5.0	10.0	5 0	5 0	5.0	5.0	5.0	6.5
75th Percentile	10.0	10.0	8.0	10 0	15.0	7.5	7 5	5.0	10 0	8.8	10.0
High	20 0	20 0	10 0	20 0	15 0	15.0	10 0	5.0	10 0	15.0	20.0
Q8 Estimated Work RVU for CPT code											
Low	0.60	0.60	0.80	0.64	0.95	0.60	0 95	0.90	0 76	0.60	1.50
25th Percentile	0 85	0 81	1 01	0 80	0 98	0 81	0 96	1.18	0 80	0.80	1.93
Median	1 00	1.00	1 10	1.00	1 00	1.00	0.98	1 45	1 00	1.00	2.70
75th Percentile	2.00	2.00	1.88	1.50	1.50	2 00	0.99	1.73	1.12	1.24	3.00
High	8.00	8.00	2 70	3.03	2 00	8 00	1.00	2 00	1.80	8.00	3.03

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	Total	AAFP	AAN	ACP	AOA	SGIM	TES	IDSA	OTHER	Typical Vignette YES	Typical Vignette NO
Typical vignette?										45	14
Yes	76%	5.0	6 0	9.0	3 0	9 0	4 0	3 0	6 0		
No	24%	1.0	3 0	6.0	1.0	1 0	0.0	0.0	2 0		
Total	**100%**	**6.0**	**9.0**	**15.0**	**4.0**	**10.0**	**4.0**	**3.0**	**8.0**		
Q2 Physician time for surveyed code											
Pre-service time											
Low	2 0	2 0	5 0	5 0	5.0	5.0	5 0	5.0	5.0	2.0	5.0
25th Percentile	5 0	5 3	8.8	5 0	5 0	5.0	5 0	7 5	5.0	5.0	7.3
Median	10.0	8.0	12.5	8 0	10.0	8 0	7 5	10 0	10 0	10.0	10.0
75th Percentile	10.0	10.0	15.0	10.0	15.0	10.0	11.3	10.0	10 0	10.0	15.0
High	30 0	10 0	16 0	30.0	15 0	15.0	15.0	10.0	15.0	16.0	30.0
Intra-service time											
Low	5 0	10.0	5.0	10 0	20.0	15.0	10.0	15 0	10.0	10.0	5.0
25th Percentile	15 0	11.3	15 0	15.0	20 0	15.0	10.0	17 5	13 8	15.0	15.0
Median	20 0	17.5	15.0	20 0	22 5	20.0	12.5	20.0	17.5	20.0	17.5
75th Percentile	25 0	20.0	20.0	30 0	25 0	25 0	15 0	22 5	30.0	25.0	25.0
High	40.0	25.0	35.0	40.0	25.0	30.0	15.0	25 0	35.0	40.0	34.0
Post-service time											
Low	3 0	3 0	5 0	5.0	5.0	5.0	5 0	10.0	10 0	3.0	5.0
25th Percentile	8 0	6 3	8 0	8 0	8 8	8.0	8.8	10 0	10.0	10.0	8.0
Median	10.0	10.0	10.0	10 0	12 5	10.0	10.0	10 0	10.0	10.0	10.0
75th Percentile	15.0	10.0	10.0	12.5	16 3	15.0	11.3	12.5	11 3	10.0	15.0
High	30.0	10 0	20 0	30.0	20.0	30.0	15 0	15.0	15.0	30.0	30.0
Q8 Estimated Work RVU for CPT code											
Low	1.00	1.80	1.00	1.16	2 27	1.10	1 00	1 50	1 50	1.00	1.55
25th Percentile	1 50	2 45	1.75	1.40	2.64	1 35	1 00	2.00	1.50	1.40	3.00
Median	2 02	3 63	2 02	1 55	3 00	1.50	1 01	2.50	2.62	1.88	3.10
75th Percentile	3.10	4 69	3 26	2.50	3 00	2 14	1 01	3.00	3 03	2.81	4.20
High	11.00	11.00	4.20	3 41	3.00	4.20	1 01	3.50	4 26	11.00	5.00

`233	Total	AAFP	AAN	ACP	AOA	SGIM	TES	IDSA	OTHER	Typical Patient YES	NO
Typical vignette?										51	9
Yes	85%	5	7 0	11	3 0	11.0	4.0	3 0	7.0		
No	15%	1	2 0	4 0	1 0	0 0	0.0	0.0	1 0		
Total	**100%**	**6.0**	**9.0**	**15.0**	**4.0**	**11.0**	**4.0**	**3.0**	**8.0**		
Q2 Physician time for surveyed code											
Pre-service time											
Low	2.0	2.0	5 0	5 0	10.0	5 0	10 0	5 0	5.0	2.0	10.0
25th Percentile	10 0	10.0	10 0	7.5	10.0	8.5	10 0	7 5	10.0	10.0	10.0
Median	10.0	10 0	15.0	10 0	12.5	10.0	10 0	10 0	10 0	10.0	15.0
75th Percentile	15.0	10.0	20.0	15 0	15 0	15.0	11.3	12 5	11.3	15.0	15.0
High	40 0	15 0	20.0	40 0	15 0	30.0	15.0	15 0	20.0	30.0	40.0
Intra-service time											
Low	10 0	12.0	15 0	15.0	25.0	20.0	10 0	15.0	10.0	10.0	20.0
25th Percentile	20.0	20.0	20 0	20 0	28.8	25.0	13 8	20 0	18.8	20.0	20.0
Median	25 0	25 0	25.0	35 0	30.0	30 0	20.0	25 0	30 0	25.0	30.0
75th Percentile	35 0	30 0	35.0	40 0	31 3	37.5	25.0	30.0	45.0	35.0	35.0
High	60 0	30.0	45 0	60.0	35 0	45.0	25 0	35.0	60 0	60.0	60.0
Post-service time											
Low	5.0	8.0	10.0	5 0	5.0	10 0	10.0	10 0	10.0	5.0	10.0
25th Percentile	10 0	10.0	10.0	10 0	12.5	13.5	10.0	12.5	10.0	10.0	10.0
Median	15 0	12.5	15.0	15 0	15 0	20.0	12 5	15.0	15.0	15.0	15.0
75th Percentile	20.0	15.0	15 0	17.5	15 0	22 5	15 0	22.5	20 0	17.5	20.0
High	45.0	15 0	30.0	40.0	15 0	45.0	15 0	30 0	20.0	45.0	40.0
Q8 Estimated Work RVU for CPT code											
Low	1 00	2.75	1 10	1 66	3 03	1.60	1.00	2.00	2.00	1.00	3.50
25th Percentile	2 00	3.23	2 50	1.90	3.29	1 85	1.75	2.80	2.00	2.00	4.00
Median	3.03	4.63	3 03	2.20	3.55	2 10	2.50	3.60	3 94	2.90	4.26
75th Percentile	4.26	6 44	4 53	3.50	3.78	3.25	3.25	4 40	4.03	4.01	4.80
High	15 00	15 00	5 00	4 26	4 00	5.00	4.00	5 20	4.26	15.00	7.00

99238	Total	AAFP	SGIM	ACP	OTHER	AOA	Typical Patient YES	Typical Patient NO
Typical vignette?							36	4
Yes	90%	5	10	11	6	4		
No	10%		1	1	1	1		
Total	**100%**	**5.0**	**11.0**	**12.0**	**7.0**	**5.0**		
Q2 Physician time for surveyed code								
Pre-service time								
Low	1 0	2 0	1.0	5.0	5.0	5 0	1.0	5.0
25th Percentile	5 0	5 0	5 0	5.5	7 5	6 0	5.0	7.3
Median	9.0	8 0	5 0	9 0	10.0	10 0	9.0	9.0
75th Percentile	10 0	10.0	10 0	10 0	15.0	10 0	10.0	12.5
High	30 0	15 0	15.0	30.0	15.0	15.0	30.0	20.0
Intra-service time								
Low	5.0	15.0	5 0	10 0	10.0	15 0	5.0	15.0
25th Percentile	15.0	15.0	12 5	17 3	15.0	20 0	15.0	18.8
Median	20 0	15.0	20.0	20.0	15 0	25.0	20.0	20.0
75th Percentile	25 0	20.0	25.0	26.3	22 5	30.0	25.0	21.3
High	45.0	20 0	30 0	40 0	30.0	45.0	45.0	25.0
Post-service time								
Low	5 0	5.0	5 0	5.0	5.0	5 0	5.0	5.0
25th Percentile	5.0	10.0	5.0	10 0	10.0	5.0	5.0	8.8
Median	10.0	15 0	10.0	10.5	10.0	12.0	10.0	15.0
75th Percentile	15.0	20 0	12 5	18.8	15 0	15.0	15.0	20.0
High	30 0	20.0	20 0	30 0	15 0	20.0	30.0	20.0
Q8 Estimated Work RVU for CPT code								
Low	1.00	1 00	1.10	1 00	1.50	1.20	1.00	1.90
25th Percentile	1.33	1 50	1.28	1.28	1 83	1 26	1.28	3.03
Median	1 50	2.00	1 40	1.40	2 00	1 64	1.50	3.96
75th Percentile	2.50	2.50	2 03	2.00	2.50	2 63	2.13	4.73
High	5.40	3.50	5 40	3 41	2.56	4 50	4.00	5.40

99239	Total	AAFP	SGIM	ACP	OTHER	AOA	Typical Patient YES	Typical Patient NO
Typical vignette?							39	1
Yes	98%	5	11	11	7	5		
No	3%			1				
Total	**100.0%**	**5.0**	**11.0**	**12.0**	**7.0**	**5.0**		
Q2 Physician time for surveyed code								
Pre-service time								
Low	3.0	3.0	5 0	5.0	10.0	8.0	3.0	10.0
25th Percentile	10.0	10.0	7 5	10.0	10 0	10 0	10.0	10.0
Median	10 0	10 0	12.0	10.0	10 0	15 0	10.0	10.0
75th Percentile	15.0	15.0	15.0	18 8	15 0	20.0	15.0	10.0
High	45 0	20 0	20.0	45.0	25.0	25 0	45.0	10.0
Intra-service time								
Low	15 0	20 0	15.0	15.0	15 0	25 0	15.0	20.0
25th Percentile	20 0	20 0	17 5	27.5	20 0	30.0	20.0	20.0
Median	30 0	30 0	30.0	35.0	30 0	30.0	30.0	20.0
75th Percentile	36 3	30 0	35.0	41 3	32.5	35 0	37.5	20.0
High	80.0	40.0	45.0	80 0	45.0	45 0	80.0	20.0
Post-service time								
Low	5 0	10 0	5.0	5.0	10 0	10.0	5.0	12.0
25th Percentile	10.0	15 0	10.0	13 5	15.0	10 0	10.0	12.0
Median	15.0	20.0	12 0	15 0	15.0	20 0	15.0	12.0
75th Percentile	20 0	20.0	20 0	25.0	20 0	20.0	20.0	12.0
High	30 0	25 0	30 0	30.0	25 0	20.0	30.0	12.0
Q8 Estimated Work RVU for CPT code								
Low	1.00	1.40	1 50	1 00	2.00	1.73	1.00	3.50
25th Percentile	1.90	2 30	1 83	1 80	2.33	2 12	1.88	3.50
Median	2 30	3 00	2.10	1.96	3 00	2.88	2.28	3.50
75th Percentile	3 50	3 50	3.02	2.83	4.50	4 13	3.50	3.50
High	6.20	4 60	6 20	4 26	5.00	6.00	6.20	3.50

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99241	Total	AACE	ACP	AOA	OTHER	ACR	ASCO	AAN	Total Vignette YES	Total Vignette NO
pical vignette?									55	23
Yes	71%	9	8	8	11	8	4	7		
No	29%	3	2	2	3	1	3	9		
Total	**100%**	**12.0**	**10.0**	**10.0**	**14.0**	**9.0**	**7 0**	**16.0**		
Q2 Physician time for surveyed code										
Pre-service time										
Low	1.0	3.0	1.0	2.0	2.0	1.0	3.0	5.0	1.0	3.0
25th Percentile	4 8	5.0	1 5	3.5	5.0	3.5	3.5	5.0	4.8	4.3
Median	5 0	5 0	4 0	5.0	5.0	5 0	4 0	7.5	5.0	5.0
75th Percentile	5 0	5 0	5.0	5 0	5 0	6 5	4.5	10.0	5.0	8.8
High	15.0	15.0	5.0	5 0	10.0	10.0	5 0	15.0	15.0	15.0
Intra-service time										
Low	5 0	5 0	5.0	5.0	7 0	10.0	9.0	10.0	5.0	5.0
25th Percentile	10.0	10.0	10 0	15.0	15 0	13 8	9.3	15.0	15.0	10.0
Median	15 0	13 5	15.0	15 0	15 0	15 0	9 5	20.0	15.0	13.5
75th Percentile	18 5	18 8	15.0	18 5	15.0	15 0	9 8	33 8	15.0	22.5
High	45.0	30.0	20 0	30.0	20.0	30 0	10.0	45.0	30.0	45.0
Post-service time										
Low	1 0	2 0	2 0	1.0	3 0	3 0	1 0	5 0	1.0	5.0
25th Percentile	5 0	5 0	4.8	2.8	5.0	4 5	2 0	8 8	5.0	5.0
Median	5.0	5.0	5.0	5.0	5.0	5 0	3.0	12.5	5.0	5.0
75th Percentile	10.0	10.0	10 0	6 3	5.0	9.3	4 0	22.5	10.0	10.0
High	30.0	15.0	15 0	10.0	8.0	10.0	5.0	30.0	20.0	30.0
Q8 Estimated Work RVU for CPT code										
Low	0 17	0 20	0.68	0 45	0 77	0 65	0.17	0 60	0.17	0.50
25th Percentile	0 70	0.88	0.70	0 60	1 00	0 71	0.17	1.00	0.70	1.00
Median	1 00	1.43	0 80	1.30	1.06	1.00	0.17	1.00	1.00	1.01
75th Percentile	1 50	2 16	0 95	1 50	1 29	1.15	0.17	1.50	1.43	1.36
High	200 00	200 00	1 00	1.50	1 53	2 38	0.17	2.06	3.00	2.06

1242	Total	AACE	ACP	AOA	OTHER	ACR	ASCO	AAN	Total Vignette YES	Total Vignette NO
Typical vignette?									57	22
Yes	72%	9	8	8	11	9	5	7		
No	28%	3	2	2	3	1	2	9		
Total	**100%**	**12.0**	**10.0**	**10.0**	**14.0**	**10.0**	**7.0**	**16.0**		
Q2 Physician time for surveyed code										
Pre-service time										
Low	1 0	2.0	1 0	2 0	5.0	3.0	5.0	5.0	1.0	1.0
25th Percentile	5 0	5.0	1 8	4 5	5.0	4 0	5.0	5.0	5.0	4.5
Median	5.0	5.0	4 5	5 0	5.0	10 0	5 0	7 0	5.0	5.0
75th Percentile	9 5	8.8	5.0	8 5	5.0	10.0	5.0	12 5	8.0	10.0
High	25 0	15 0	5.0	10 0	10.0	10.0	5.0	25.0	15.0	25.0
Intra-service time										
Low	5.0	10.0	8.0	5.0	20 0	12.0	15.0	10 0	5.0	8.0
25th Percentile	15.0	15 0	13 8	22.5	20 0	20.0	16.3	17.8	20.0	10.8
Median	25 0	15 0	20 0	30 0	27.5	27.5	17 5	30.0	27.5	17.5
75th Percentile	30.0	23.8	26 3	30.0	30.0	30 5	18.8	37.5	30.0	20.0
High	60.0	35.0	30.0	30.0	30.0	40 0	20 0	60 0	40.0	60.0
Post-service time										
Low	3.0	4 0	5 0	3.0	5.0	3.0	5 0	7.0	3.0	5.0
25th Percentile	5.0	6 3	5 0	4.5	5.0	5 0	5.0	10.0	5.0	5.0
Median	9.5	10.0	7.5	6.5	5.0	5 0	5 0	10.0	8.5	10.0
75th Percentile	10 0	10.0	11 3	11.3	10.0	9.3	5 0	22.5	10.0	11.3
High	30.0	15 0	15 0	20.0	10.0	10.0	5.0	30.0	20.0	30.0
Q8 Estimated Work RVU for CPT code										
Low	0.50	0.50	1.10	1.00	1.15	1.30	0 95	0 80	0.50	1.00
25th Percentile	1 34	1 50	1 32	1 53	1 59	1.36	0.95	1 10	1.32	1.49
Median	1.58	1 75	1 40	1 68	1.73	2 00	0.95	2 00	1.55	1.60
75th Percentile	2.22	2 40	1.50	1.86	2.14	2 27	0.95	2 53	2.20	1.93
High	250.00	250.00	1.50	2.20	3.42	2 67	0 95	30 00	30.00	2.56

1243	Total	AACE	ACP	AOA	OTHER	ACR	ASCO	AAN	Total Vignette YES	NO
Typical vignette?									65	15
Yes	81%	9	10	8	11	9	5	13		
No	19%	4		2	3	1	2	3		
Total	**100%**	**13.0**	**10.0**	**10.0**	**14.0**	**10.0**	**7.0**	**16.0**		
Q2 Physician time for surveyed code										
Pre-service time										
Low	2.0	4.0	2 0	2.0	5.0	3.0	8.0	5.0	2.0	5.0
25th Percentile	5 0	7 5	4 5	4.8	6 5	5 0	8 5	5.0	5.0	6.5
Median	10 0	10 0	5 0	6 5	8.5	10.0	9 0	12.0	10.0	10.0
75th Percentile	10.0	10.0	10.0	11 3	10.0	10 5	9 5	15.0	10.0	15.0
High	20.0	20.0	10 0	15 0	20.0	15.0	10.0	20 0	20.0	20.0
Intra-service time										
Low	10 0	15 0	10 0	10.0	28.0	15 0	30 0	15.0	10.0	15.0
25th Percentile	25 0	20 0	18.5	27 5	33 8	31 3	30 0	27.5	25.0	25.0
Median	35.0	30 0	29 0	40 0	40.0	41.5	30 0	40 0	35.0	30.0
75th Percentile	40.0	32.5	32 5	40.0	41.3	45.0	30.0	52 5	40.0	42.5
High	60.0	60.0	40 0	45.0	50 0	60.0	30 0	60 0	60.0	60.0
Post-service time										
Low	3.0	5.0	5.0	3 0	5.0	4.0	5 0	10.0	3.0	5.0
25th Percentile	7.0	7 5	6.5	4 8	9.3	7.8	6 3	11 0	7.0	10.0
Median	10 0	10.0	9 0	7 5	10.0	10.0	7.5	15 0	10.0	10.0
75th Percentile	15.0	15 0	15 0	12.5	15 0	14.3	8.8	20 0	15.0	17.5
High	40.0	20.0	20.0	20.0	25 0	30 0	10.0	40.0	30.0	40.0
Q8 Estimated Work RVU for CPT code										
Low	1.00	1.20	1 80	1.70	1.10	1.88	2.40	1 00	1.00	1.83
25th Percentile	1 97	1 96	1 90	2.00	1 99	1 95	2 40	1.70	1.90	2.00
Median	2.01	2 28	2 00	2 15	2.12	2.02	2.40	3.00	2.02	2.00
75th Percentile	3.00	3.58	2.00	2.45	2.83	2 73	2 40	3.31	2.90	3.06
High	300 00	300.00	2.10	3 00	3.84	3.86	2.40	35 00	35.00	3.50

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99244	Total	AACE	ACP	AOA	OTHER	ACR	ASCO	AAN	Total Vignette YES	Total Vignette NO
pical vignette?									70	13
Yes	84%	10	10	10	12	9	6	13		
No	16%	4			2	1	2	4		
Total	**100%**	**14.0**	**10.0**	**10.0**	**14.0**	**10.0**	**8.0**	**17.0**		
Q2 Physician time for surveyed code										
Pre-service time										
Low	5.0	5.0	5 0	5 0	5.0	5 0	10 0	5 0	5.0	5.0
25th Percentile	8.5	10.0	5.0	5.0	10 0	7.5	10 0	10.0	7.0	10.0
Median	10.0	10.0	7.0	10 0	12 5	15.0	10.0	10.0	10.0	10.0
75th Percentile	15 0	15.0	10.0	15 0	15.0	15.0	20 0	15.0	15.0	15.0
High	30 0	20 0	15 0	15.0	25 0	15.0	30.0	20 0	30.0	20.0
Intra-service time										
Low	15.0	20.0	25.0	15 0	30.0	20 0	40.0	20 0	15.0	20.0
25th Percentile	35 0	32 5	33 8	38 8	42 5	42.5	50 0	35 0	35.0	30.0
Median	45 0	40.0	40.0	60.0	60.0	55.0	60 0	50.0	45.0	45.0
75th Percentile	60 0	42 5	48 8	60.0	60.0	65.5	60.0	67.5	60.0	60.0
High	80 0	75.0	60 0	60 0	75.0	70.0	60.0	80 0	80.0	80.0
Post-service time										
Low	3 0	5 0	5 0	3 0	5.0	5 0	10 0	12 0	3.0	5.0
25th Percentile	10 0	12 5	12.3	6 5	12 0	10.0	10 0	17 5	10.0	10.0
Median	15 0	15 0	15.0	11.0	15 0	10.0	10 0	20.0	15.0	15.0
75th Percentile	20.0	17.5	20 0	14.0	30 0	14.8	25 0	30.0	20.0	20.0
High	40.0	20.0	25 0	25 0	40.0	30 0	40 0	40.0	40.0	40.0
Q8 Estimated Work RVU for CPT code										
Low	1 20	1 92	2.83	2 00	1 33	2 40	3 45	1.20	1.20	1.92
25th Percentile	2.48	2 65	2.85	2 28	2.31	2.85	3 54	1.93	2.70	2.13
Median	3.02	3 21	3.00	2.83	3.06	3.03	3 63	2.88	3.17	2.50
75th Percentile	3.79	4.05	3.00	3.68	3 74	3.64	3.71	3.94	3.78	3.63
High	462 00	350.00	3 40	4.50	462.00	4 38	3.80	4 26	462.00	4.26

1245	Total	AACE	ACP	AOA	OTHER	ACR	ASCO	AAN	Total Vignette YES	NO
Typical vignette?									77	17
Yes	82%	11	8	10	11	11	11	15		
No	18%	3	2		3	1	5	3		
Total	**100%**	**14.0**	**10.0**	**10.0**	**14.0**	**12.0**	**16.0**	**18.0**		
Q2 Physician time for surveyed code										
Pre-service time										
Low	5.0	6 0	5.0	5.0	5.0	5 0	5 0	5.0	5.0	6.0
25th Percentile	10.0	10 0	9.0	5 0	10 0	12.5	15 0	15 0	10.0	10.0
Median	15 0	10.0	10.0	8 5	15 0	15.0	15.0	15 0	15.0	15.0
75th Percentile	20 0	15.0	10 0	20 0	16.3	16.3	20.0	20 0	20.0	15.0
High	30 0	20.0	20.0	20.0	30.0	20 0	30.0	30.0	30.0	30.0
Intra-service time										
Low	20.0	30 0	45.0	20 0	50 0	25.0	45 0	35 0	20.0	45.0
25th Percentile	50 0	45.0	45.0	48 8	58 8	60 0	60.0	55 0	50.0	56.3
Median	60 0	60.0	47 5	67.5	77.5	70.0	70.0	60.0	60.0	65.0
75th Percentile	77.5	60.0	67 5	80 0	80.0	75.0	80.0	75 0	75.0	78.8
High	120.0	90 0	80.0	90.0	90.0	120.0	80.0	120.0	120.0	90.0
Post-service time										
Low	3 0	10.0	5 0	3 0	5.0	10 0	15 0	15 0	3.0	10.0
25th Percentile	15 0	15.0	15.0	8.8	13 8	15.0	15.0	20 0	15.0	16.3
Median	20.0	20 0	20.0	12.5	20.0	16.0	22.5	30 0	20.0	22.5
75th Percentile	30 0	20 0	21.3	16.3	48.8	30 0	30 0	37.5	30.0	30.0
High	60 0	30.0	30.0	30.0	60.0	45 0	60 0	45.0	60.0	45.0
Q8 Estimated Work RVU for CPT code										
Low	1 40	2.10	3.78	2 00	1.47	3.70	3.78	1 40	1.40	2.00
25th Percentile	3 77	3 88	3.85	2.66	2 63	3 77	3.90	2.25	3.78	3.23
Median	4.00	4.13	4.00	3 58	3 50	4.00	4 28	4.26	4.00	4.55
75th Percentile	4 55	4.70	4.00	4.23	4 85	4 45	4.55	5 69	4.30	4.90
High	400.00	400.00	4 00	4 50	6.39	5 01	6 00	90.00	400.00	6.37

`251	Total	AAN	AOA	ACP	ASH	OTHER	Total Vignette YES	NO
Typical vignette?							30	15
Yes	67%	4	4	9	4	9		
No	33%	7	1	4	1	2		
Total	**100%**	**11.0**	**5.0**	**13.0**	**5.0**	**11.0**		
Q2 Physician time for surveyed code								
Pre-service time								
Low	3.0	5 0	4 0	5 0	3 0	5.0	3.0	5.0
25th Percentile	5 0	7.5	5 0	5.0	5.0	5 0	5.0	10.0
Median	10 0	10.0	10.0	10.0	5.0	7.5	7.5	10.0
75th Percentile	10.0	15 0	10 0	10.0	10.0	10.0	10.0	15.0
High	30 0	30 0	15 0	15.0	15 0	30.0	30.0	20.0
Intra-service time								
Low	10.0	15.0	15 0	10 0	10.0	10.0	10.0	15.0
25th Percentile	15.0	17 5	25 0	15.0	10.0	12.5	15.0	17.5
Median	20 0	20 0	30.0	20.0	20.0	20.0	20.0	20.0
75th Percentile	30 0	30.0	30 0	20 0	20.0	27.5	25.0	30.0
High	60 0	60.0	30.0	60 0	30.0	60 0	60.0	60.0
Post-service time								
Low	5.0	5 0	10 0	5.0	5 0	5.0	5.0	5.0
25th Percentile	5.0	7 5	10 0	5 0	7 0	5.0	5.0	5.0
Median	10 0	15.0	12 5	10 0	10 0	5.0	10.0	10.0
75th Percentile	15 0	20.0	15.0	15 0	15.0	12.5	15.0	15.0
High	60.0	30.0	15 0	30.0	20.0	60.0	60.0	30.0
Q8 Estimated Work RVU for CPT code								
Low	0 70	0.78	1.00	0 70	0 79	0 70	0.70	0.80
25th Percentile	1 00	0.85	1.04	0.90	1.21	1 01	1.00	1.00
Median	1.15	1.10	1.78	1.00	1 30	1.10	1.10	1.50
75th Percentile	1 73	1 43	2.74	1.85	1 51	1.33	1.51	2.30
High	3 45	2 50	3.45	3 20	2 30	2.50	3.45	2.50

RVS Update Survey
July 8, 2005

99252	Total	AAN	AOA	ACP	ASH	OTHER	Total Vignette YES	Total Vignette NO
pical vignette?							9	36
Yes	80%	6	4	12	4	10		
No	20%	5	1	1	1	1		
Total	**100%**	**11.0**	**5.0**	**13.0**	**5.0**	**11.0**		
Q2 Physician time for surveyed code								
Pre-service time								
Low	5 0	5 0	5.0	5.0	5 0	5 0	5.0	5.0
25th Percentile	5 0	7.5	5.0	8 8	5 0	5 0	5.0	10.0
Median	10 0	15.0	10.0	10.0	10 0	10 0	10.0	15.0
75th Percentile	15.0	17.5	10 0	15.0	10.0	15 0	15.0	15.0
High	30 0	30.0	15 0	20.0	20.0	30.0	30.0	20.0
Intra-service time								
Low	10 0	12 0	20.0	15.0	10.0	15.0	10.0	15.0
25th Percentile	20 0	17.5	30.0	20 0	15 0	22 5	20.0	20.0
Median	35 0	40.0	35.0	30 0	40.0	30 0	30.0	40.0
75th Percentile	40 0	40.0	40.0	40.0	40.0	42 5	40.0	45.0
High	60.0	60.0	40 0	60.0	45.0	60.0	60.0	60.0
Post-service time								
Low	5 0	10 0	5.0	5.0	10 0	5 0	5.0	5.0
25th Percentile	10 0	10.0	10.0	10.0	10 0	5 0	10.0	15.0
Median	10 0	15.0	10 0	10.0	10 0	10.0	10.0	15.0
75th Percentile	15 0	21.0	20 0	15.0	15.0	12.5	15.0	20.0
High	60.0	30 0	20.0	20.0	20.0	60.0	60.0	30.0
Q8 Estimated Work RVU for CPT code								
Low	1 00	1.00	1.20	1.35	1 15	1 40	1 15	1.00
25th Percentile	1.50	1.46	2.74	1.50	1.50	1 50	1.50	1.63
Median	1.81	1 75	3.38	1.75	1.58	1 71	1.65	2.30
75th Percentile	2.80	2.38	3 65	3 15	2.60	2.09	2.59	2.90
High	20 00	2 50	4.08	20.00	2.87	3.00	20.00	3.25

RVS Update Survey
July 8, 2005

99253	Total	AAN	AOA	ACP	ASH	OTHER	Total Vignette YES	NO
Typical vignette?							36	13
Yes	73%	6	5	11	4	10		
No	27%	6	0	5	1	1		
Total	**100%**	**12.0**	**5.0**	**16.0**	**5.0**	**11.0**		
Q2 Physician time for surveyed code								
Pre-service time								
Low	5 0	5.0	6 0	5 0	10.0	5.0	5.0	5.0
25th Percentile	10.0	10.0	10 0	10.0	10.0	7.5	10.0	10.0
Median	10.0	13 5	15.0	10.0	10.0	10.0	10.0	10.0
75th Percentile	20.0	20 0	15.0	15.0	15 0	20 0	15.0	20.0
High	30.0	30.0	20 0	20 0	20 0	30 0	30.0	20.0
Intra-service time								
Low	10 0	13 0	30.0	10 0	15.0	20.0	13.0	10.0
25th Percentile	30.0	25 0	40.0	30.0	30 0	27.5	30.0	30.0
Median	40 0	45.0	40.0	40 0	55 0	50 0	40.0	45.0
75th Percentile	53 8	55.0	40.0	45 0	55 0	57 5	55.0	50.0
High	60 0	60.0	45 0	55.0	60 0	60.0	60.0	60.0
Post-service time								
Low	5 0	5.0	5.0	5.0	15 0	8 0	5.0	5.0
25th Percentile	10 0	15 0	10.0	8 8	15 0	10 0	10.0	10.0
Median	15 0	20.0	15 0	12 5	15.0	10 0	15.0	20.0
75th Percentile	20.0	20.0	20 0	15.0	20.0	17.5	16.3	20.0
High	60.0	45 0	25.0	20.0	25.0	60.0	60.0	45.0
Q8 Estimated Work RVU for CPT code								
Low	1 18	1.20	1.60	1 20	1 18	1 70	1.18	1.20
25th Percentile	2 00	1 76	2.65	1.89	2 37	2 20	2.00	1.35
Median	2.50	2 50	3.63	2.50	3.00	2.50	2.65	2.50
75th Percentile	3.01	3 00	4.38	2.80	3 01	2.77	3.03	2.75
High	4.75	3 50	4 75	4.30	3 45	3 50	4.75	3.45

99254

	Total	AAN	AOA	ACP	ASH	OTHER	Total Vignette YES	Total Vignette NO
Typical vignette?							40	9
Yes	82%	8	4	14	5	9		
No	18%	4	1	2	0	2		
Total	**100%**	**12.0**	**5.0**	**16.0**	**5.0**	**11.0**		
Q2 Physician time for surveyed code								
Pre-service time								
Low	5.0	5 0	8.0	5.0	10.0	5 0	5.0	5.0
25th Percentile	10 0	10 0	10.0	10.0	15.0	10 0	10.0	10.0
Median	15 0	20 0	15.0	15 0	15.0	15.0	15.0	20.0
75th Percentile	20 0	26.3	15 0	20.0	20.0	27 5	20.0	30.0
High	30.0	30 0	20 0	30.0	25.0	30 0	30.0	30.0
Intra-service time								
Low	15 0	15 0	30.0	20.0	15.0	20.0	15.0	30.0
25th Percentile	35.0	30.0	45 0	42 5	40 0	32.5	30.0	50.0
Median	50.0	60.0	50 0	50.0	80.0	60.0	50.0	50.0
75th Percentile	71.3	80 0	50 0	60.0	85.0	75 0	75.0	60.0
High	95.0	90.0	55.0	80.0	95 0	80 0	95.0	80.0
Post-service time								
Low	5 0	5 0	15.0	5.0	15.0	10.0	5.0	10.0
25th Percentile	10 8	15.0	15.0	10.0	20.0	10.0	10.0	15.0
Median	20.0	30.0	15 0	17.5	25 0	15.0	15.0	30.0
75th Percentile	25.0	30 0	20 0	20.0	25 0	22 5	25.0	30.0
High	60 0	45 0	25 0	30.0	30.0	60.0	60.0	45.0
Q8 Estimated Work RVU for CPT code								
Low	1.26	1 40	2 40	2 00	1.26	2.40	1.26	2.00
25th Percentile	3 00	2 46	3 15	3.05	3.50	3.00	3.00	3.13
Median	3 50	3 60	4.20	3 45	3 70	3.78	3.60	3.50
75th Percentile	3 80	3 88	5.00	3 58	3.70	3.80	3.80	3.75
High	5 00	4.50	5.00	5 00	3.96	4.00	5.00	4.50

RVS Update Survey
July 8, 2005

99255	Total	AAN	AOA	ACP	ASH	OTHER	Total Vignette YES	NO
Typical vignette?							40	9
Yes	82%	9	5	12	5	9		
No	18%	3		4		2		
Total	**100%**	**12.0**	**5.0**	**16.0**	**5.0**	**11.0**		
Q2 Physician time for surveyed code								
Pre-service time								
Low	5 0	5.0	10.0	5 0	10.0	5 0	5.0	5.0
25th Percentile	10 0	13.8	10.0	10.0	20.0	15 0	10.0	20.0
Median	20.0	20 0	15.0	20.0	20.0	20 0	20.0	30.0
75th Percentile	30.0	30 0	20 0	20 0	30 0	30 0	20.0	30.0
High	40.0	40.0	30.0	35.0	30.0	40.0	40.0	35.0
Intra-service time								
Low	15.0	15.0	50 0	30.0	20 0	25 0	15.0	40.0
25th Percentile	50.0	46 3	55 0	48.8	60.0	50.0	50.0	60.0
Median	60.0	60.0	60 0	60.0	100 0	60 0	60.0	60.0
75th Percentile	75.0	78.8	60.0	75 0	115.0	82.5	75.0	80.0
High	120.0	110.0	65.0	110 0	120 0	110.0	120.0	110.0
Post-service time								
Low	5.0	5 0	15 0	10 0	20 0	15 0	5.0	15.0
25th Percentile	16.3	20.0	15.0	10.0	25 0	20 0	15.0	30.0
Median	25.0	30 0	15 0	22.5	30 0	20 0	20.0	40.0
75th Percentile	35 0	45 0	20.0	30.0	45.0	35 0	30.0	45.0
High	60 0	50.0	30.0	45 0	45.0	60.0	60.0	50.0
Q8 Estimated Work RVU for CPT code								
Low	1.33	1 60	3.60	2.60	1 33	3 30	1.33	2.00
25th Percentile	4 00	3.01	4 28	4.03	3 85	3 88	3.96	4.50
Median	4 50	4.26	5 25	4.35	4 30	4 50	4.28	5.00
75th Percentile	5 00	4.80	6 00	4.88	4 86	4 50	4.67	5.50
High	7.00	5.50	6 00	7 00	5.46	5.00	6.00	7.00

RVS Update Survey

99281

July 8, 2005

	Total	ACEP	Other	Typ Vignette YES	Typ Vignette NO
pical vignette?				99	2
Yes	98 0%	99	0		
No	2.0%	1	1		
Total	**100.0%**	**100**	**1**		
Q8 Estimated Work RVU for CPT code					
Low	0.17	0 17	1.00	0.17	1.00
25th Percentile	0.39	0.40	1.00	0.38	1.00
Median	0 50	0.50	1 00	0.46	1.00
75th Percentile	0 80	0 80	1.00	0.80	1.00
High	1.01	1 01	1 00	1.01	1.00

99282

	Total	ACEP	Other	Typ Vignette YES	Typ Vignette NO
Typical vignette?				98	3
Yes	97.0%	98 0	0 0		
No	3.0%	2.0	1 0		
Total	**100.0%**	**100.0**	**1.0**		
Q8 Estimated Work RVU for CPT code					
Low	0.52	0.52	1.50	0.52	1.00
25th Percentile	0 75	0.75	1 50	0.75	1.13
Median	1.00	1.00	1.50	0.95	1.25
75th Percentile	1.22	1 21	1.50	1.20	1.38
High	2 50	2.50	1.50	2.50	1.50

RVS Update Survey
July 8, 2005

99283	Total	ACEP	Other	Typ Vignette YES	NO
Typical vignette?				80	11
Yes	87.9%	80 0			
No	12.1%	10.0	1 0		
Total	**100.0%**	**90.0**	**1.0**		
Q8 Estimated Work RVU for CPT code					
Low	1.01	1.01	2.75	1.01	1.30
25th Percentile	1.60	1.60	2.75	1.60	1.62
Median	2.00	2 00	2 75	2.00	1.75
75th Percentile	2.50	2.50	2 75	2.50	1.62
High	4 00	4.00	2 75	4.00	2.75

RVS Update Survey
July 8, 2005

99284

	Total	ACEP	Other	Typ Vignette YES	Typ Vignette NO
pical vignette?				92	9
Yes	91 1%	92 0			
No	8.9%	8 0	1 0		
Total	**100.0%**	**100.0**	**1.0**		
Q8 Estimated Work RVU for CPT code					
Low	1 50	1.50	3.50	1.50	3.10
25th Percentile	2 56	2.55	3 50	2.50	3.25
Median	3.14	3.13	3.50	3.00	3.34
75th Percentile	3 41	3 41	3.50	3.41	3.25
High	5 00	5.00	3 50	5.00	4.09

RVS Update Survey
July 8, 2005

99285

	Total	ACEP	Other	Typ Vignette YES	Typ Vignette NO
Typical vignette?				92	7
Yes	92.9%	91 0	1.0		
No	7 1%	7.0			
Total	**100.0%**	**98**	**1**		
Q8 Estimated Work RVU for CPT code					
Low	1 80	1.8	4 5	1.80	4.00
25th Percentile	3.80	3.8	4.5	3.75	4.08
Median	4.19	4.0	4.5	4.17	4.20
75th Percentile	4.50	4 4	4.5	4.50	4.08
High	7.00	7.0	4 5	7.00	4.60

Workgroup 5 - Handout: Emergency Department Visit Time

	99281 Survey	99282 Survey	99283 Survey	99284 Survey	99285 Survey
Q.2 Physician Time for Surveyed Codes					
64% of respondents completed this section					
Pre-Service Time (in minutes)					
Low	1.0	1.0	1.0	1.0	1.0
25th%	1.0	2.0	3.0	4.0	5.0
Median	2.0	3.0	5.0	5.0	8.0
75%	3.0	5.0	5.0	9.0	10.0
High	15.0	15.0	15.0	30.0	30.0
Intra-Service Time (in minutes					
Low	2.0	2.0	4.0	10.0	12.0
25th%	5.0	8.0	13.0	20.0	28.0
Median	7.0	10.0	18.0	25.0	40.0
75%	10.0	15.0	25.0	40.0	50.0
High	18.0	25.0	45.0	120.0	180.0
Post-Service Time (in minutes)					
Low	2.0	2.0	2.0	2.0	2.0
25th%	2.0	3.0	5.0	8.0	10.0
Median	4.0	5.0	7.0	10.0	15.0
75%	5.0	7.0	10.0	15.0	20.0
High	15.0	16.0	20.0	45.0	60.0
Total Median	**13.0**	**15.0**	**30.0**	**40.0**	**63.0**
Q.3 Rate Complexity/Intensity					
Surveyed CPT Code					
Pre-service time	1.11	1.54	2.43	3.30	4.10
Intra-service time	1.40	2.23	3.15	4.20	5.00
Post-service time	1.21	1.90	2 81	3.70	4.60
Reference Service CPT	90862	99217	99234	99235	99236
Pre-service time	1.00	2.14	2.44	3.50	4 20
Intra-service time	1.12	1.91	3.17	4.00	4.80
Post-service time	1.00	2.14	2.96	3 80	4 60
Estimated Work RVU for CPT Code					
Low	0.17	0.52	1.01	1.50	1.80
25th	0.39	0.75	1.60	2.56	3.80
Median	0.50	1.00	2.00	3.14	4.19
75th	0.80	1.22	2.50	3.41	4 50
High	1.01	2.50	4.00	5.00	7.00

RVS Update Survey - 99291, 99292 (Critical Care)
August 2, 2005

99291	Total	ACCP, ATS, SCCM	ASA	ASCO	ASH	Typical Vignette Yes	No
Typical vignette?						70	10
Yes	87.50%	58	5	6	1		
No	12 50%	8	1	1	0		
Total	**100%**	**66**	**6**	**7**	**1**		
Physician time for surveyed code							
Pre-service time							
Low	0	0	10	5	30	0	6.25
25th Percentile	10	10	10	7 5	30	10	6.25
Median	15	15	10	12	30	15	10
75th Percentile	20	20	10	17.5	30	20	13.75
High	45	45	15	30	30	45	20
Intra-service time							
Low	15	15	20	30	40	15	30
25th Percentile	30	30	22 5	37 5	40	30	30
Median	40	40	30	45	40	40	35
75th Percentile	60	60	33.75	60	40	60	47.5
High	90	74	50	90	40	90	60
Post-service time							
Low	0	0	10	10	20	0	5
25th Percentile	11.25	11	10	15	20	10	14
Median	20	17 5	12.5	20	20	17.5	17.5
75th Percentile	20	20	18.75	30	20	23	20
High	45	45	30	30	20	45	30
Estimated Work RVU for CPT code							
Low	0.5	0.5	3.75	2 06	1.15	0.5	2
25th Percentile	4.29	4.5	4.875	3.25	1.15	4.3	4.275
Median	5 1	5.415	6 195	4	1.15	5.295	4.59
75th Percentile	6 06	6.1875	6 472	4.28	1 15	6	6.0425
High	16 8	16.8	8	4.3	1 15	8.52	16.8

99292	Total	SCCM	ASA	ASCO	ASH	Typical Vignette Yes	No	Blank
Typical vignette?						60	10	10
Yes	75%	50	4	5	1			
No	12.50%	8	1	1	0			
Blank	12.50%	8	1	1	0			
Total	100%	66	6	7	1			
Physician time for surveyed code								
Intra-service time								
Low	10	10	30	20	40	10	15	25
25th Percentile	30	30	30	27.5	40	30	22.5	26.25
Median	30	30	30	30	40	30	30	30
75th Percentile	30	30	30	35	40	30	30	30
High	60	60	30	60	40	60	45	30
Estimated Work RVU for CPT code								
Low	0.5	0.5	1.5	1.25	1 25	0.5	2	1.5
25th Percentile	2	2	2 3125	1.75	1.25	1.95	2.22	2.4375
Median	2.66	2.685	2 725	2.25	1 25	2.5	2.975	3.5
75th Percentile	3.5	3 5	3 7375	3.2	1.25	3.2875	3.8	4
High	8.4	8 4	4	4 65	1.25	7	8.4	6

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99201 Global Period: XXX Specialty Society RVU: **0.45**

RUC RVU: **0.45**

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new 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 patients 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

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial office visit for a 25-year-old out-of-town patient for refill of a topical prescription medication.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

- Review the medical history form completed by the patient and vital signs obtained by clinical staff

Description of Intra-Service Work:

- Obtain a problem focused history
- Perform a problem focused examination
- Formulate a diagnosis and develop a treatment plan (straight forward medical decision making)
- Discuss diagnosis and treatment options with the patient
- Discuss the need for preventive health care with the patient
- Reconcile medication(s) as necessary
- Write prescription(s) as necessary

Description of Post-Service Work:

- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005		
Presenter(s):	Joseph R. Schlecht, D.O. (AOA)		
Specialty(s):	American Academy of Family Physicians, American Association of Clinical Endocrinology, American College of Physicians, American Nurses Association, American Osteopathic Association, American Podiatric Medical Association, American Academy of Dermatology		
CPT Code:	99201		
Sample Size:	4907	**Resp n:** 239	**Response:** 4.87 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.15	0.60	**0.98**	1.20	30.00
Pre-Service Evaluation Time:			**3.0**		
re-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	3.00	8.00	**10.00**	15.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23), 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99341	XXX	1.01

CPT Descriptor 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 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 20 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
86320	XXX	0.37

CPT Descriptor 1 Immunoelectrophoresis; serum

MPC CPT Code 2	Global	Work RVU
97110	XXX	0.45

CPT Descriptor 2 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

Other Reference CPT Code	Global	Work RVU
90471	XXX	0.17

CPT Descriptor Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 7.9 %

TIME ESTIMATES (Median)	**CPT Code: 99201**	**Key Reference CPT Code: 99341**
Median Pre-Service Time	3.00	6.50
Median Intra-Service Time	10.00	20.00
Median Immediate Post-service Time	5 00	10 00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**18.00**	**36.50**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.30	1.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.30	1.60
Urgency of medical decision making	1.30	1.30

Technical Skill/Physical Effort (Mean)

Technical skill required	1.40	1.30
Physical effort required	1.30	1.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.20	1.40
Outcome depends on the skill and judgment of physician	1.50	1.90
Estimated risk of malpractice suit with poor outcome	1.60	1.90

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.10	1.40
Intra-Service intensity/complexity	1.50	1.70
Post-Service intensity/complexity	1.20	1 40

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In response to the question, "Has the work of performing this service changed in the past 5 years?," approximately 57% of respondents said "No." Further, we did not identify any compelling evidence outside the survey to support a change in the current work RVUs assigned to this code. Accordingly, we recommend no change in the current work RVUs for this service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 42% No 57%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 3% I do not agree 97%
B. Patients requiring this service are now:
   more complex (more work) 94% less complex (less work) 1% no change 5%
C. The usual site-of-service has changed:
   from outpatient to inpatient 1% from inpatient to outpatient 18% no change 81%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99202 | Global Period: XXX | **Recommended Work Relative Value**
Specialty Society RVU: **0.88**
RUC RVU: **0.88**

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new 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 patients 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

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial office visit for a 42-year-old female patient with a history and rash consistent with poison ivy not responding to over-the-counter medication

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the medical history form completed by the patient and vital signs obtained by clinical staff

Description of Intra-Service Work:
- Obtain an expanded problem focused history
- Perform an expanded problem focused examination
- Formulate a diagnosis and develop a treatment plan (straight forward medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Reconcile medication(s)
- Write prescription(s)
- Order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Joseph R. Schlecht, D.O. (AOA)
Specialty(s):	American Academy of Family Physicians, American Association of Clinical Endocrinology, American College of Physicians, American Nurses Association, American Osteopathic Association, American Podiatric Medical Association, American Academy of Dermatology

CPT Code:	99202		
Sample Size:	4907	Resp n: 239	Response: 0.00 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.30	0.97	**1.36**	2.00	30.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	14.00	**15.00**	20.00	75.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	5.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99341	XXX	1.01

CPT Descriptor 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 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 20 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
92012	XXX	0.67

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

MPC CPT Code 2	Global	Work RVU
93307	XXX	0.92

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; complete

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 5.8 %

TIME ESTIMATES (Median)	**CPT Code: 99202**	**Key Reference CPT Code: 99341**
Median Pre-Service Time	5.00	6.50
Median Intra-Service Time	15.00	20.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**25.00**	**36.50**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.20	2.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.20	2.00
Urgency of medical decision making	2.10	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.10	1.80
Physical effort required	1 80	1.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	1.60
Outcome depends on the skill and judgment of physician	2.40	1.90
Estimated risk of malpractice suit with poor outcome	2.20	1.80

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.60	1.80
Intra-Service intensity/complexity	2.30	2.10
Post-Service intensity/complexity	1.90	1.80

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In response to the question, "Has the work of performing this service changed in the past 5 years?," 51.5% of respondents said "No." Further, we did not identify any compelling evidence outside the survey to support a change in the current work RVUs assigned to this code. Accordingly, we recommend no change in the current work RVUs for this service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Ias the work of performing this service changed in the past 5 years? Yes 48% No 51%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 1% I do not agree 99%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 1% from inpatient to outpatient 14% no change 85%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99203 | Global Period: XXX | **Recommended Work Relative Value**
Specialty Society RVU: **1.92**
RUC RVU: **1.34**

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new 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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial office visit for a 63-year old female with hypertension presents for a pre- employment physical after moving to the area. Her blood pressure has been adequately controlled with her current medication on home blood pressure monitoring

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the medical history form completed by the patient and vital signs obtained by clinical staff
- Communicate with other health professionals

Description of Intra-Service Work:
- Obtain a detailed history
- Perform a detailed examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (low complexity medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Reconcile medication(s)
- Write prescription(s)
- Order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Joseph R. Schlecht, D.O. (AOA)

Specialty(s):	American Academy of Family Physicians, American Association of Clinical Endocrinology, American College of Physicians, American Nurses Association, American Osteopathic Association, American Podiatric Medical Association
CPT Code:	99203

Sample Size:	4907	**Resp n:** 239	**Response:** 4.87 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.95	1.49	**1.92**	2.33	45.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	6.00	20.00	**25.00**	30.00	90.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23), 99212 (15), 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99386	XXX	1.88

CPT Descriptor Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
99396	XXX	1.53

CPT Descriptor Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 5.0 %

TIME ESTIMATES (Median)	**CPT Code: 99203**	**Key Reference CPT Code: 99386**
Median Pre-Service Time	5.00	5.00
Median Intra-Service Time	25.00	40.00
Median Immediate Post-service Time	10.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**40.00**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.00	2.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.00
Urgency of medical decision making	3.00	2.90

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.70
Physical effort required	2.60	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.40
Outcome depends on the skill and judgment of physician	3.20	3.00
Estimated risk of malpractice suit with poor outcome	3.10	3.30

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.40	2.20
Intra-Service intensity/complexity	3.10	3.00
Post-Service intensity/complexity	2.80	2.40

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Almost 76% of respondents indicated that the work of performing this service had changed in the last five years. They also consistently rated the intensity/complexity for each time period and all but one component of this service higher than that of the key reference service (99386). This explains why the median estimated work RVU (1.92) is slightly higher than the work RVU of 99386 (1.88) even though the median time for the survey code is less than that for 99386 in the RUC database. We also believe it is worth noting that both this code and 99386 are for new patients and that this code includes an element of medical decision making that is not present in 99386, which is a preventive medicine service.

We also think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code. For instance, there is a greater expectation that physicians will be proactive in disease prevention and diagnosing and treating illness. Although many diagnostic and screening tests existed ten years ago, they have become more widely xpected (e.g., mammograms for women over 40, colonoscopies for all over 50, etc.) and more widely available. Further, physicians must be more opportunistic in addressing prevention, such that an initial office visit for a pre-employment physical also represents the opportunity to address, for example, the need for influenza immunization, smoking cessation, and colonoscopy screening, as appropriate. This need to be opportunistic is reinforced by the growing emphasis on ambulatory quality measures and pay-for-performance programs that focus on such measures.

At the same time, there has been an increase in the complexity of data to be evaluated and care to be managed at such visits. Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intraservice intensity of E/M services and increases the pre- and post-service time involved. There is also more polypharmacy and an explosion in the number of clinical guidelines that are good examples of what is considered optimal care. Not only are there more guidelines, but the therapeutic targets are much more aggressive. For example, JNC 7 sets SBP goals of less than 140 (130 for diabetic and coronary patients), HbA1c goals are less than 7.0, and LDL goals for CAD patients are in the 70 range. All of this demands more physician work. Add to this all of the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions has increased.

Similarly, there are more informed patients who want to and should be actively involved in decision-making, and they bring more information with them to their visits. These patients are presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press. As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than it did ten years ago when E/M codes were last reviewed. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

Other compelling evidence for a change in work for this code is the additional documentation requirements added to physician work. As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines.

There is also the greater role that genomics plays in the evaluation and potential management of patients. Ten years ago, the human genome had not been mapped. Now, it has. With the mapping and sequencing of the human genome, medical professionals from essentially all specialties have turned their attention to investigating the role genes play in health and disease, and genetic disease represents an important part of medical practice. Diagnosing a genetic disorder not only allows for disease-specific management options but also has implications for the affected individual's entire family. As such, a working understanding of the underlying concepts of genetic disease is necessary for today's practicing physician, and routine clinical practice requires integration of these fundamental concepts for use in accurate diagnosis and ensuring appropriate referrals for patients with genetic disease and their families. In addition, genomic information will become integral to the selection of treatment in a variety of disease conditions, adding a new dimension to disease management. All of this expands the knowledge base required for each E/M service since this information must be integrated with the traditional cognitive base.

Finally, there is evidence that the intensity of E/M services has increased over time. Support for the increased intensity of E/M services, particularly office visits, may be found in the results of the National Ambulatory Medical Care Survey. Data from this survey published by the Centers for Disease Control and Prevention in 2003 reflect increasing complexity and intensity of physician work in office practice from 1992-2002. Patients were older, had more complex iagnoses, more discussion of treatment and more mention of drugs used in treatment in 2002 than was the case in 1992. This is reinforced by the fact that survey respondents cited patients as more complex as the most common reason the work of this service has changed over the last five years.

Based on this compelling evidence and survey respondents' indication that the current work has changed and is undervalued, we are recommending an increase in the work RVUs for this code from 1.34 to 1.92, the median of our survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 75% No 24%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 95% less complex (less work) 0% no change 5%
C. The usual site-of-service has changed:
   from outpatient to inpatient 2% from inpatient to outpatient 19% no change 79%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99204 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **2.78**
RUC RVU: **2.30**

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new 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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial office visit for a 60-year-old female who has a history of hypertension, osteoarthritis, and morbid obesity. She is complaining of heart palpitations with occasional dizziness. Past medical history includes total abdominal hysterectomy 15 years previously for dysfunctional uterine bleeding. She has had no follow-up in five years

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the medical history form completed by the patient and vital signs obtained by clinical staff
- Communicate with other health professionals

Description of Intra-Service Work:
- Obtain a comprehensive history
- Perform a comprehensive examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (moderate complexity medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Reconcile medication(s)
- Write prescription(s)
- Order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Joseph R. Schlecht, D.O. (AOA)

Specialty(s):	American Academy of Family Physicians, American Association of Clinical Endocrinology, American College of Physicians, American Nurses Association, American Osteopathic Association, American Podiatric Medical Association
CPT Code:	99204

Sample Size:	4907	**Resp n:** 239	**Response:** 4.87 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	2.03	**2.78**	3.44	60.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	30.00	**40.00**	45.00	120.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**12.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99386	XXX	1.88

CPT Descriptor Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
99235	XXX	3.41

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date 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) requiring admission are of moderate severity.

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 6.2 %

TIME ESTIMATES (Median)	CPT Code: 99204	Key Reference CPT Code: 99386
Median Pre-Service Time	5.00	5.00
Median Intra-Service Time	40.00	40.00
Median Immediate Post-service Time	12.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**57.00**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.10	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.10	3.80
Urgency of medical decision making	3.90	3.70

Technical Skill/Physical Effort (Mean)

Technical skill required	3 90	3.80
Physical effort required	3.30	3 30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.80
Outcome depends on the skill and judgment of physician	4.30	4.20
Estimated risk of malpractice suit with poor outcome	4.00	3.70

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.20	3.30
Intra-Service intensity/complexity	4.20	4.00
Post-Service intensity/complexity	3.70	3.40

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Almost 85% of respondents indicated that the work of performing this service had changed in the last five years. They lso rated the intensity/complexity for all but one time period or component of this service at or above that of the key reference service (99386). Thus, respondents view this service as more intense and complex than 99386, which explains why the median estimated work RVU (2.78) is higher than the work RVU of 99386 (1.88) even though the time for the survey code is only two minutes more than that for 99386 in the RUC database. We also believe it is worth noting that both this code and 99386 are for new patients and that this code includes an element of medical decision making that is

not present in 99386, which is a preventive medicine service. We further note that the median estimated work RVU (2.78) is less the work RVU (3.41) for 99235, the other reference code cited most often by respondents, even though both codes involve a comprehensive history and examination, medical decision making of moderate complexity, and presenting problem(s) of moderate severity.

We also think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code. For instance, there is a greater expectation that physicians will be proactive in disease prevention and diagnosing and treating illness. Although many diagnostic and screening tests existed ten years ago, they have become more widely expected (e.g., mammograms for women over 40, colonoscopies for all over 50, etc.) and more widely available. Further, physicians must be more opportunistic in addressing prevention, such that an initial office visit also represents the opportunity to address, for example, the need for influenza immunization, smoking cessation, and colonoscopy screening, as appropriate. This need to be opportunistic is reinforced by the growing emphasis on ambulatory quality measures and pay-for-performance programs that focus on such measures

At the same time, there has been an increase in the complexity of data to be evaluated and care to be managed at such visits. Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intraservice intensity of E/M services and increases the pre- and post-service time involved. There is also more polypharmacy and an explosion in the number of clinical guidelines that are good examples of what is considered optimal care. Not only are there more guidelines, but the therapeutic targets are much more aggressive. For example, JNC 7 sets SBP goals of less than 140 (130 for diabetic and coronary patients), HbA1c goals are less than 7.0, and LDL goals for CAD patients are in the 70 range. All of this demands more physician work. Add to this all of the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions has increased.

Similarly, there are more informed patients who want to and should be actively involved in decision-making, and they bring more information with them to their visits. These patients are presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press. As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than it did ten years ago when E/M codes were last reviewed. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

Other compelling evidence for a change in work for this code is the additional documentation requirements added to physician work. As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines.

There is also the greater role that genomics plays in the evaluation and potential management of patients. Ten years ago, the human genome had not been mapped. Now, it has. With the mapping and sequencing of the human genome, medical professionals from essentially all specialties have turned their attention to investigating the role genes play in health and disease, and genetic disease represents an important part of medical practice. Diagnosing a genetic disorder not only allows for disease-specific management options but also has implications for the affected individual's entire family. As such, a working understanding of the underlying concepts of genetic disease is necessary for today's practicing physician, and routine clinical practice requires integration of these fundamental concepts for use in accurate diagnosis and ensuring appropriate referrals for patients with genetic disease and their families. In addition, genomic information will become integral to the selection of treatment in a variety of disease conditions, adding a new dimension to disease management. All of this expands the knowledge base required for each E/M service since this information must be integrated with the traditional cognitive base.

Finally, there is evidence that the intensity of E/M services has increased over time. Support for the increased intensity of E/M services, particularly office visits, may be found in the results of the National Ambulatory Medical Care Survey Data from this survey published by the Centers for Disease Control and Prevention in 2003 reflect increasing complexity and intensity of physician work in office practice from 1992-2002. Patients were older, had more complex diagnoses, more discussion of treatment and more mention of drugs used in treatment in 2002 than was the case in 1992

This is reinforced by the fact that survey respondents cited patients as more complex as the most common reason the work of this service has changed over the last five years.

Based on this compelling evidence and survey respondents' indication that the current work has changed and is ndervalued, we are recommending an increase in the work RVUs for this code from 2.00 to 2.78, the median of our survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 84% No 15%

A. This service represents new technology that has become more familiar (i.e., less work)·
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 4% from inpatient to outpatient 33% no change 63%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99205 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **3.78**
RUC RVU: **3.00**

CPT Descriptor: Office or other outpatient visit for the evaluation and management of a new 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 patients 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial office visit for a 63-year-old male with Type 2 diabetes mellitus, coronary artery disease, osteoarthritis, chronic bronchitis, hypertension, gastroesophageal reflux, and hyperlipidemia who presents with a 20 pound weight loss, dysphagia, and abdominal pain. He is on multiple medications and has not seen a physician for 18 months.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the medical history form completed by the patient and vital signs obtained by clinical staff
- Communicate with other health professionals

Description of Intra-Service Work:
- Obtain a comprehensive history
- Perform a comprehensive examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (high complexity medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Reconcile medication(s)
- Write prescription(s)
- Order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Joseph R. Schlecht, D.O. (AOA)

Specialty(s):	American Academy of Family Physicians, American Association of Clinical Endocrinology, American College of Physicians, American Nurses Association, American Osteopathic Association, American Podiatric Medical Association
CPT Code:	99205

Sample Size:	4907	**Resp n:** 239	**Response:** 4.87 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1 50	3.00	**3.78**	4.38	60.00
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	20.00	40.00	**50.00**	60.00	180 00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date 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) requiring admission are of high severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 1 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

MPC CPT Code 2	Global	Work RVU
95951	XXX	5.99

CPT Descriptor 2 Monitoring for localization of cerebral seizure focus by cable or radio 16 or more channel telemetry, combined EEG and video recording and interpretation (eg, for presurgical localization), each 24 hours.

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 11.2 %

TIME ESTIMATES (Median)	**CPT Code: 99205**	**Key Reference CPT Code: 99236**
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	50.00	110.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**75.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.80	4.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.90	4.90
Urgency of medical decision making	4.60	4 70

Technical Skill/Physical Effort (Mean)

Technical skill required	4.80	4.80
Physical effort required	4.90	4.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.70	4.90
Outcome depends on the skill and judgment of physician	4.60	4.80
Estimated risk of malpractice suit with poor outcome	3.80	4.10

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.80	4 60
Intra-Service intensity/complexity	4.80	4.80
Post-Service intensity/complexity	4.40	4.60

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Approximately 82% of respondents indicated that the work of performing this service had changed in the last five years. Respondents' rating of the intensity/complexity for this service compared to the key reference service (99236) was mixed. For instance, respondents indicated that the complexity/intensity in the intraservice period was equivalent and that the complexity/intensity in the pre- and post-service periods was greater for the reference code than the survey code. Likewise, respondents thought that the intensity of some components (i.e., amount and complexity of medical records, risk of complications) was greater for the survey code, and for other components (i.e., urgency of decision making,

technical skill, physical effort, and risk of malpractice), respondents thought 99236 was more intense. For some components (i.e., range of diagnoses, outcome depends on skill/judgment), respondents thought the survey code and reference code were of equal instensity.

t appears, on balance, then that respondents rated the survey code as less complex and intense than the key reference service (99236). They also attributed less time to the survey code than is attributed to 99236 in the RUC database We believe this explains why the median estimated work RVU (3.80) is less than the work RVU of 99236 (4 26). We also believe it is worth noting that both this code and 99236 involve a comprehensive history, a comprehensive examination, and medical decision making of high complexity, and both may include presenting problem(s) of high severity.

We think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code. For instance, there is a greater expectation that physicians will be proactive in disease prevention and diagnosing and treating illness. Although many diagnostic and screening tests existed ten years ago, they have become more widely expected (e.g., mammograms for women over 40, colonoscopies for all over 50, etc.) and more widely available. Further, physicians must be more opportunistic in addressing prevention, such that an initial office visit also represents the opportunity to address, for example, the need for influenza immunization, smoking cessation, and colonoscopy screening, as appropriate. This need to be opportunistic is reinforced by the growing emphasis on ambulatory quality measures and pay-for-performance programs that focus on such measures.

At the same time, there has been an increase in the complexity of data to be evaluated and care to be managed at such visits. Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intraservice intensity of E/M services and increases the pre- and post-service time involved. There is also more polypharmacy and an explosion in the number of clinical guidelines that are good examples of what is considered optimal care. Not only are there more guidelines, but the therapeutic targets are much more aggressive. For example, JNC 7 sets SBP goals of less than 140 (130 for diabetic and coronary patients), HbA1c goals are less than 7.0, and LDL goals for CAD patients are in the 70 range. All of this demands more physician work Add to this all of the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results o be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions has increased.

Similarly, there are more informed patients who want to and should be actively involved in decision-making, and they bring more information with them to their visits. These patients are presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press. As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than it did ten years ago when E/M codes were last reviewed. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

Other compelling evidence for a change in work for this code is the additional documentation requirements added to physician work. As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines.

There is also the greater role that genomics plays in the evaluation and potential management of patients. Ten years ago, the human genome had not been mapped. Now, it has. With the mapping and sequencing of the human genome, medical professionals from essentially all specialties have turned their attention to investigating the role genes play in health and disease, and genetic disease represents an important part of medical practice. Diagnosing a genetic disorder not only allows for disease-specific management options but also has implications for the affected individual's entire family. As such, a working understanding of the underlying concepts of genetic disease is necessary for today's practicing physician, and routine clinical practice requires integration of these fundamental concepts for use in accurate 'iagnosis and ensuring appropriate referrals for patients with genetic disease and their families. In addition, genomic nformation will become integral to the selection of treatment in a variety of disease conditions, adding a new dimension to disease management. All of this expands the knowledge base required for each E/M service since this information must be integrated with the traditional cognitive base.

Finally, there is evidence that the intensity of E/M services has increased over time. Support for the increased intensity of E/M services, particularly office visits, may be found in the results of the National Ambulatory Medical Care Survey. Data from this survey published by the Centers for Disease Control and Prevention in 2003 reflect increasing complexity and intensity of physician work in office practice from 1992-2002. Patients were older, had more complex diagnoses, more discussion of treatment and more mention of drugs used in treatment in 2002 than was the case in 1992. This is reinforced by the fact that survey respondents cited patients as more complex as the most common reason the work of this service has changed over the last five years.

Based on this compelling evidence and survey respondents' indication that the current work has changed and is undervalued, we are recommending an increase in the work RVUs for this code from 2 67 to 3 80, the median of our survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 82% No 17%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 97% less complex (less work) 0% no change 3%
C. The usual site-of-service has changed:
   from outpatient to inpatient 6% from inpatient to outpatient 37% no change 57%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99211 Global Period: XXX Specialty Society RVU: **0.17**

RUC RVU: **0.17**

CPT Descriptor: Office or other outpatient visit for the evaluation and management of an established patient, that may or 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

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Office visit, established patient, a 58-year-old male presenting for nursing blood pressure check. The blood pressure is 130/83. His blood pressure is acceptable.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- None

Description of Intra-Service Work:
- Provide supervision to the clinical staff, review any data of concern, answer any questions which arise and provide guidance to the clinical staff as necessary

Description of Post-Service Work:
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005					
Presenter(s):	Walter Larimore, M.D. (AAFP)					
Specialty(s):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American College of Rheumatology, American Nurses Association, American Osteopathic Association, American Society of Clinical Oncology, The Endocrine Society					
CPT Code:	99211					
Sample Size:	4127	**Resp n:** 243		**Response:** 0.00 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.15	0.18	**0.38**	0.75	15.00
re-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		1.00	3.00	**5.00**	5.00	20.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**3.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38), 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
3790	XXX	0.38

CPT Descriptor Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
95015	XXX	0.15

CPT Descriptor 1 Intracutaneous (intradermal) casts, sequential and incramental, with drugs, biologicals, or venoms, immediate type reaction, specify number of tests

MPC CPT Code 2	Global	Work RVU
73560	XXX	0.17

CPT Descriptor 2 Radiologic examination, knee; one or two views

Other Reference CPT Code	Global	Work RVU
	XXX	

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 16 **% of respondents:** 6.5 %

TIME ESTIMATES (Median)	CPT Code: 99211	Key Reference CPT Code: 93790
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	5.00	15.00
Median Immediate Post-service Time	3.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**8.00**	**15.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.20	1.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.30	1.30
Urgency of medical decision making	1.30	1.30

Technical Skill/Physical Effort (Mean)

Technical skill required	1.30	1.40
Physical effort required	1.10	1.10

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.30	1.50
Outcome depends on the skill and judgment of physician	1.50	1.70
Estimated risk of malpractice suit with poor outcome	1.60	1.60

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.10	1.10
Intra-Service intensity/complexity	1.20	1.30
Post-Service intensity/complexity	1.20	1.50

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

In response to the question, "Has the work of performing this service changed in the past 5 years?," approximately two thirds of respondents said "No." Further, we could identify no compelling evidence outside the survey to support a change in the current work RVUs assigned to this code. Accordingly, we recommend no change in the current work RVUs for this service.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Ias the work of performing this service changed in the past 5 years? Yes 33% No 66%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 6% I do not agree 94%
B. Patients requiring this service are now:
   more complex (more work) 86% less complex (less work) 2% no change 12%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 25% no change 75%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99212 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **0.62**
RUC RVU: **0.45**

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: 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 patients 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Office visit, established patient, a mildly symptomatic 20 year old female with upper respiratory complaints consistent with an upper respiratory tract infection

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review the medical history form completed by the patient and vital signs obtained by clinical staff

Description of Intra-Service Work:
- Obtain a problem focused history (including response to treatment at last visit and reviewing interval correspondence or medical records received)*
- Perform a problem focused examination*
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (straightforward medical decision making)*
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Reconcile medication(s)
- Write prescription(s)
- Order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary

* Two of these three components required

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Walter Larimore, M.D. (AAFP)

Specialty(s):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American College of Rheumatology, American Nurses Association, American Osteopathic Association, American Society of Clinical Oncology, The Endocrine Society
CPT Code:	99212

Sample Size:	4127	**Resp n:** 243		**Response:** 5 88 %	
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	0.30	0.62	**0.95**	1.30	20.00
Pre-Service Evaluation Time:			**3.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	2.00	10.00	**10.00**	10.00	30.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99347	XXX	0.76

CPT Descriptor 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; 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.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
90853	XXX	0.59

CPT Descriptor 1 Group psychotherapy (other than of a multiple-family group)

MPC CPT Code 2	Global	Work RVU
99433	XXX	0.62

CPT Descriptor 2 Subsequent hospital care, for the evaluation and management of a normal newborn, per day

Other Reference CPT Code	Global	Work RVU
	XXX	

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 7.4 %

TIME ESTIMATES (Median)	CPT Code: 99212	Key Reference CPT Code: 99347
Median Pre-Service Time	3.00	5.00
Median Intra-Service Time	10.00	15.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0 0	0.00
Median Total Time	**18.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.10	2.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.10	2.30
Urgency of medical decision making	2.00	2.20

Technical Skill/Physical Effort (Mean)

Technical skill required	2.10	2.30
Physical effort required	1.80	2.30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.10
Outcome depends on the skill and judgment of physician	2.30	2.30
Estimated risk of malpractice suit with poor outcome	2.30	2 40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	1.60	1.80
Intra-Service intensity/complexity	2.10	2.10
Post-Service intensity/complexity	1.80	1.90

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

A majority of respondents indicated that the work for 99212 had not changed in the last five years. However, their estimation of the work RVUs for this service (median = 0.95) is substantially higher than the current work RVUs for this code (i.e., 0.45). We noted that this code has not been surveyed before and concluded that survey respondents think the work has not changed but is currently undervalued.

We also think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code For instance, there is a greater expectation that physicians will be proactive in disease prevention and diagnosing and treating illness. This is as true at this level of service as it is at other levels. Physicians must be more opportunistic in addressing prevention, such that an upper respiratory complaint also represents the opportunity to address, for example, nmunization status and smoking cessation, as appropriate. This need to be opportunistic is reinforced by the growing emphasis on ambulatory quality measures and pay-for-performance programs that focus on such measures.

At the same time, patients are presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press. This is true for even minor problems, such as those addressed in a 99212 visit. As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than it did ten years ago when E/M codes were last reviewed. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

Other compelling evidence for a change in work for this code is the additional documentation requirements added to physician work. As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines.

Based on this compelling evidence and survey respondents' indication that the current work is undervalued, we are recommending an increase in the work RVUs for this code from 0.45 to 0.62, the 25th percentile of our survey. We are recommending the 25th percentile in deference to respondents' view that the work has not changed and because we believe it is more in line with the work RVU of the key reference service and the other work RVUs we are recommending for this family.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 45% No 54%

A. This service represents new technology that has become more familiar (i.e., less work):
I agree 1% I do not agree 99%
B. Patients requiring this service are now:
more complex (more work) 93% less complex (less work) 0% no change 7%
C. The usual site-of-service has changed:
from outpatient to inpatient 1% from inpatient to outpatient 30% no change 69%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99221 Global Period: XXX Specialty Society RVU: **2.56**
RUC RVU: **1.88**

CPT Descriptor: Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: 1) a detailed or comprehensive history; 2) a detailed or comprehensive 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 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43-year-old male is admitted to the hospital with low back pain after failing outpatient treatment. A recent MRI of the lumbar spine demonstrated minimal bulging disks without nerve root compromise, stenosis, or lumbar spine structural abnormality. There is no significant past medical history and he is on no medications. The patient did not complain of any lower extremity numbness or weakness and denied any difficulty with bladder or bowel control.

Percentage of Survey Respondents who found Vignette to be Typical: 68%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family
- Obtain and review necessary past results or records not available on the unit
- Perform evaluation/management in other sites of service earlier the same day

Description of Intra-Service Work:
- Review medical records and data available on the unit
- Obtain a detailed or comprehensive history
- Perform a detailed or comprehensive physical exam
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (straightforward or low complexity medical decision making)
- Discuss diagnosis and treatment options with the patient and/or family
- Consider discharge needs of patient
- Communicate with other health care professionals
- Write/review admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005

Presenter(s):	Doug Leahy, M.D (ACP)
Specialty(s):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Osteopathic Association
CPT Code:	99221

Sample Size:	660	**Resp n:** 64	**Response:** 9.69 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.95	1 88	**2.56**	3 00	6.00
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	20.00	**30.00**	30.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**13.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99234	XXX	2.56

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three 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 consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
93312	XXX	2.20

CPT Descriptor 1 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

MPC CPT Code 2	Global	Work RVU
99298	XXX	2.75

CPT Descriptor 2 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 27 **% of respondents:** 42.1 %

TIME ESTIMATES (Median)	CPT Code: 99221	Key Reference CPT Code: 99234
Median Pre-Service Time	10.00	10.00
Median Intra-Service Time	30.00	60.00
Median Immediate Post-service Time	13.00	15.00
Median Critical Care Time	0 0	0 00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**53.00**	**85.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.33	2.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.42	1.30
Urgency of medical decision making	2.35	2.43
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.40	2.52
Physical effort required	2.12	2.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.33	2.13
Outcome depends on the skill and judgment of physician	2.72	2.57
Estimated risk of malpractice suit with poor outcome	3.07	2.74

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.02	2.00
Intra-Service intensity/complexity	2.50	2.50
Post-Service intensity/complexity	2.19	2.26

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Approximately 61% of survey respondents indicated that they believe the work associated with this code has changed in the last five years. Although the 61% represents a solid majority, we believe that the response to this question would have been higher if the respondents were aware that this code has not been reviewed since the first Five-Year Review, approximately 10 years ago. Survey respondents' median recommended work RVU for this code is 2.56 and the 25% percentile is 1.88, which is substantially above the current work RVU of 1.28-indicating that many respondents who stated that the work has not changed in the past five years, in fact, believe the work RVU is currently undervalued.

Approximately 69% of respondents indicated that the vignette describes their typical patient.

Approximately 42% of respondents selected 99234 as the key reference service code. The current key reference service work RVU of 2.56 is equal to the median work RVU provided by the respondents for the surveyed code. The survey respondents' intensity/complexity measure rankings for the surveyed code are consistent with their rankings for the reference service code: the mean Mental Effort and Judgment values are nearly identical; the reference code has a slightly higher mean Technical Skill/Physical Effort values; the surveyed code has a higher mean Psychological Stress values; the mean Time Segments values are nearly identical.

Recommending the median work RVU for the surveyed code that is equal to the reference service code is further supported by the fact that CPT maintains the following identical three key components for both 99221 and 99234: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity.

Further, we have identified compelling evidence outside the survey, described below, to supplement our recommended work RVU for this code.

Additional Documentation

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed because the physician work surveys were conducted in 1995. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation in the previous five years. These survey results were published in the December 2002 Journal of Clinical Oncology article "the American Society of Clinical Oncology 2001 Presidential Initiative: Impact of Regulatory Burden on Quality Cancer Care," by Lawrence Finhorn et al.

The E/M documentation requirements add to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The advent of electronic databases, while facilitating access to patient information, has created new work for clinicians. Medication and problem lists must be accurately maintained by providers. Further, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

Adherence to Evidence-Based Hospital Care Processes Performance Measures

Efforts that track hospital adherence to evidence based care processes that encourage improvement in their quality of care have resulted in physicians being more proactive in treating inpatients. The article "Quality of Care in U.S. Hospitals as Reflected by Standardized Measures, 2002-2004, written by Scott Williams et al, in the July 21, 2005 New England Journal of Medicine, describes consistent improvement in measures reflecting the processes of care for acute myocardial infraction, heart failure, and pneumonia. The study described in the article examined how hospitals performed on 17 standard care process measures implemented by the Joint Commission on Accreditation of Healthcare Organizations in July 2002. The study involved data collected from over 3,000 accredited hospitals over a two-year period. Using the first quarter in which data was reported as a baseline, the hospitals improved significantly in 15 of 17 care process measures, with no measure showing a significant deterioration, over the two-year period.

Selected process measures that pertaining to initial hospital care services for which hospitals showed significant improvement are:

Acute Myocardial Infarction

- Aspirin with 24 hours after admission
- Beta blocker within 24 hours after admission

Pneumonia

- Oxygenation assessment within 24 hours after admission
- Blood cultures collected by initiation of antibiotic therapy

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVUs for this code from 1.28 to 2.56, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 61% No 38%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 91% less complex (less work) 0% no change 9%
C. The usual site-of-service has changed:
   from outpatient to inpatient 8% from inpatient to outpatient 31% no change 61%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99222 Global Period: XXX Specialty Society RVU: **3.43**

RUC RVU: **2.56**

CPT Descriptor: Initial hospital care, per day, for the evaluation and management of a 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 patients and/or family's needs. 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

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male is admitted to the hospital with progressive shortness of breath over the last week. He feels more short of breath than ever before. His history reveals many years of hypertension and several years of congestive heart failure. He has been taking his diuretic every other day to save money.

Percentage of Survey Respondents who found Vignette to be Typical: 75%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family
  Obtain and review necessary past results or records not available on the unit
- Perform evaluation/management in other sites of service earlier the same day

Description of Intra-Service Work:
- Review medical records and data available on the unit
- Obtain a comprehensive history
- Perform a comprehensive physical exam
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (moderate complexity medical decision making)
- Discuss diagnosis and treatment options with the patient and/or family
- Consider discharge needs of patient
- Communicate with other health care professionals
- Write/review admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Doug Leahy, M.D (ACP)
Specialty(s):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Osteopathic Association
CPT Code:	99222

Sample Size: 660	Resp n: 64	Response: 9.69 %
Sample Type: Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	3.00	**3.43**	3.80	8.50
Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	15.00	30.00	**40.00**	50.00	75.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	20.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30), 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
9235	XXX	3.41

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three components a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity Counseling and/or coordination of care with other providers consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99440	XXX	2.93

CPT Descriptor 1 Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

MPC CPT Code 2	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 26 **% of respondents:** 40.6 %

TIME ESTIMATES (Median)	**CPT Code: 99222**	**Key Reference CPT Code: 99235**
Median Pre-Service Time	15.00	10.00
Median Intra-Service Time	40.00	75.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**75.00**	**100.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	3.69	3.50
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.54
Urgency of medical decision making	3.73	3.58
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.59	3.50
Physical effort required	3.10	3.04
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.75	3.42
Outcome depends on the skill and judgment of physician	3.86	3.63
Estimated risk of malpractice suit with poor outcome	3.88	3.54

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	3.20
Intra-Service intensity/complexity	3.66	3.52
Post-Service intensity/complexity	3.42	3.24

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Approximately 82% of survey respondents indicated that they believe the work associated with this code has changed in the last five years.

75% of respondents indicated that the vignette describes their typical patient.

Approximately 41% of respondents selected 99235 as the key reference service code. The current key reference service work RVU of 3.41 is roughly equivalent to the median work RVU provided by the survey respondents. All of the survey respondents' intensity/complexity measure rankings for the surveyed code are higher than their rankings for the reference service code expect for the Time Segments "pre-service intensity/complexity" value.

Recommending the median work RVU for the surveyed code that is roughly equivalent to the reference service code is further supported by the fact that CPT maintains the following identical three key components for both 99222 and 99235: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.

Further, we have identified compelling evidence outside the survey, described below, to supplement our recommended work RVU for this code.

Additional Documentation

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed because the physician work surveys were conducted in 1995. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation in the previous five years. These survey results were published in the December 2002 Journal of Clinical Oncology article "the American Society of Clinical Oncology 2001 Presidential Initiative: Impact of Regulatory Burden on Quality Cancer Care," by Lawrence Einhorn et al.

The E/M documentation requirements add to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The advent of electronic databases, while facilitating access to patient information, has created new work for clinicians. Medication and problem lists must be accurately maintained by providers. Further, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

Adherence to Evidence-Based Hospital Care Processes Performance Measures

Efforts that track hospital adherence to evidence based care processes that encourage improvement in their quality of care have resulted in physicians being more proactive in treating inpatients. The article "Quality of Care in U.S Hospitals as Reflected by Standardized Measures, 2002-2004, written by Scott Williams et al, in the July 21, 2005 New England Journal of Medicine, describes consistent improvement in measures reflecting the processes of care for acute myocardial infraction, heart failure, and pneumonia. The study described in the article examined how hospitals performed on 17 standard care process measures implemented by the Joint Commission on Accreditation of Healthcare Organizations in July 2002. The study involved data collected from over 3,000 accredited hospitals over a two-year period. Using the first quarter in which data was reported as a baseline, the hospitals improved significantly in 15 of 17 care process measures, with no measure showing a significant deterioration, over the two-year period.

Selected process measures that pertaining to initial hospital care services for which hospitals showed significant improvement are:

Acute Myocardial Infarction

- Aspirin with 24 hours after admission
- Beta blocker within 24 hours after admission

Pneumonia

- Oxygenation assessment within 24 hours after admission
  Blood cultures collected by initiation of antibiotic therapy

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVUs for this code from 2.14 to 3.43, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 82% No 17%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 97% less complex (less work) 0% no change 3%
C. The usual site-of-service has changed:
   from outpatient to inpatient 2% from inpatient to outpatient 19% no change 79%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99223 | Global Period: XXX | **Recommended Work Relative Value** Specialty Society RVU: **4.26** RUC RVU: **3.78**

CPT Descriptor: Initial hospital care, per day, for the evaluation and management of a 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 patients and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female is admitted to the hospital with cellulitis around a right great toe ulcer. She has a history of Type 2 diabetes mellitus, ischemic cardiomyopathy, atherosclerotic peripheral vascular disease, hypertension, chronic renal insufficiency, and dementia. She is a widow living in a nursing home.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family
  Obtain and review necessary past results or records not available on the unit
- Perform evaluation/management in other sites of service earlier the same day

Description of Intra-Service Work:
- Review medical records and data available on the unit
- Obtain a comprehensive history
- Perform a comprehensive physical exam
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (high complexity medical decision making)
- Discuss diagnosis and treatment options with the patient and/or family
- Consider discharge needs of patient
- Communicate with other health care professionals
- Write/review admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Doug Leahy, M.D. (ACP)
Specialty(s):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Osteopathic Association
CPT Code:	99223

Sample Size: 660	**Resp n:** 65	**Response:** 9.84 %
Sample Type: Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	3.00	4 00	**4.26**	5.00	10.00
Pre-Service Evaluation Time:			**20.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	20.00	40.00	**55.00**	70.00	100.00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**25.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 1 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

MPC CPT Code 2	Global	Work RVU
95951	XXX	5.99

CPT Descriptor 2 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 31 **% of respondents:** 47.6 %

TIME ESTIMATES (Median)	CPT Code: 99223	Key Reference CPT Code: 99236
Median Pre-Service Time	20.00	0 00
Median Intra-Service Time	55 00	110.00
Median Immediate Post-service Time	25.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**100.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.75	4 62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.87	4.66
Urgency of medical decision making	4.76	4.82

Technical Skill/Physical Effort (Mean)

Technical skill required	4 65	4 62
Physical effort required	3.88	3.79

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.77	4.69
Outcome depends on the skill and judgment of physician	4.77	4.62
Estimated risk of malpractice suit with poor outcome	4 43	4 59

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.31	4.30
Intra-Service intensity/complexity	4.85	4.77
Post-Service intensity/complexity	4.63	4.60

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

93% of survey respondents indicated that they believe the work associated with this code has changed in the last five ears-with every respondent who stated that the work has increased selecting the patients are "more complex (more work)" option as a contributing factor.

88% of respondents indicated that the vignette describes their typical patient.

Approximately 48% of respondents selected 99236 as the key reference service code. The current key reference service work RVU of 4.26 is roughly equivalent to the median work RVU provided by the respondents for the surveyed code All of the survey respondents' intensity/complexity measure rankings for the surveyed code are higher than their rankings for the reference service code except for the Mental Effort and Judgment "urgency of medical decision making" value and the Psychological Stress "estimated risk of malpractice suit with poor outcome" value

Recommending the median work RVU for the surveyed code that is rough equivalent to the reference service code is further supported by the fact that CPT maintains the following identical three key components for both 99223 and 99236: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.

Further, we have identified compelling evidence outside the survey, described below, to supplement our recommended work RVU for this code.

Additional Documentation

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed because the physician work surveys were conducted in 1995. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation in the previous five years. These survey results were published in the December 2002 Journal of Clinical Oncology article "the American Society of Clinical Oncology 2001 Presidential Initiative: Impact of Regulatory Burden on Quality Cancer Care," by Lawrence Einhorn et al.

The E/M documentation requirements add to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The advent of electronic databases, while facilitating access to patient information, has created new work for clinicians. Medication and problem lists must be accurately maintained by providers. Further, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

Adherence to Evidence-Based Hospital Care Processes Performance Measures

Efforts that track hospital adherence to evidence based care processes that encourage improvement in their quality of care have resulted in physicians being more proactive in treating inpatients. The article "Quality of Care in U.S. Hospitals as Reflected by Standardized Measures, 2002-2004, written by Scott Williams et al, in the July 21, 2005 New England Journal of Medicine, describes consistent improvement in measures reflecting the processes of care for acute myocardial infraction, heart failure, and pneumonia. The study described in the article examined how hospitals performed on 17 standard care process measures implemented by the Joint Commission on Accreditation of Healthcare Organizations in July 2002. The study involved data collected from over 3,000 accredited hospitals over a two-year period. Using the first quarter in which data was reported as a baseline, the hospitals improved significantly in 15 of 17 care process measures, with no measure showing a significant deterioration, over the two-year period.

Selected process measures that pertaining to initial hospital care services for which hospitals showed significant improvement are:

Acute Myocardial Infarction

- Aspirin with 24 hours after admission

- Beta blocker within 24 hours after admission

Pneumonia

Oxygenation assessment within 24 hours after admission
- Blood cultures collected by initiation of antibiotic therapy

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVUs for this code from 2.99 to 4.3, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

`. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 93% No 7%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 7% from inpatient to outpatient 18% no change 75%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99231 | Global Period: XXX | **Recommended Work Relative Value** Specialty Society RVU: **1.00** RUC RVU: **0.76**

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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent hospital visit for a 43-year-old male who presented to the hospital with low back pain after failing outpatient treatment. A recent MRI of the lumbar spine demonstrated minimal bulging disks without nerve root compromise, stenosis, or lumbar spine structural abnormality. The patient did not complain of any lower extremity numbness or weakness and denied any difficulty with bladder or bowel control. The patient's pain has improved with medical management, but is not controlled on oral medications nor is ready for discharge home.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family

Description of Intra-Service Work:
- Review medical records and data available on the unit
- Obtain a problem focused history*
- Perform a problem focused physical exam*
- Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) (straightforward or low complexity medical decision making)*
- Discuss diagnosis and treatment options with the patient and/or family
- Consider discharge needs of patient
- Communicate with other health care professionals
- Write/review orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family

* Two of these three components required

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005

Presenter(s):	Larry Martinelli, M.D. (IDSA)
Specialty(s):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Osteopathic Association, Infectious Diseases Society of America, The Endocrine Society, Infectious Disease Society of America
;PT Code:	99231

Sample Size:	3710	**Resp n:** 60	**Response:** 1 61 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.60	0.85	**1.00**	2.00	8.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	10.00	**15.00**	15.00	24.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99347	XXX	0.76

CPT Descriptor 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; 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.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
78707	XXX	0.96

CPT Descriptor 1 Kidney imaging with vascular flow and function; single study without pharmacological intervention

MPC CPT Code 2	Global	Work RVU
99391	XXX	1.02

CPT Descriptor 2 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; infant (age under 1 year)

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)	**CPT Code: 99231**	**Key Reference CPT Code: 99347**
Median Pre-Service Time	5.00	5.00
Median Intra-Service Time	15.00	15.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0 00
Median Office Visit Time	0.0	0.00
Median Total Time	**25.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	2.07	1.75
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.22	1.67
Urgency of medical decision making	2.14	1.58
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.30	2.25
Physical effort required	1.96	2.17
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.16	1.67
Outcome depends on the skill and judgment of physician	2.39	2.25
Estimated risk of malpractice suit with poor outcome	2.67	1.92

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.83	1.50
Intra-Service intensity/complexity	2.22	1.92
Post-Service intensity/complexity	1.95	1.67

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Approximately 62% of survey respondents indicated that they believe the work associated with this code has changed in the last five years. Although the 62% represents a solid majority, we believe that the response to this question would have been higher if the respondents were aware that this code has not been reviewed since the first Five-Year Review, approximately 10 years ago. Survey respondents' median recommended work RVU for this code is 1.00; the 25% percentile is 0.85, which is substantially above the current work RVU of 0.64; and the low is 0.60-indicating that many

respondents who stated that the work has not changed in the past five years, in fact, believe the work RVU is currently undervalued.

80% of respondents indicated that the vignette describes their typical patient.

20% of respondents selected 99347 as the key reference service code. The current key reference service work RVU is 0.74, which is higher than the current surveyed code work RVU of .0.64 but less than the survey median work RVU of 1.00. The respondents' surveyed code median work RVU is supported by the comparison of the intensity/complexity measure rankings. All of the survey respondents' intensity/complexity measure rankings for the surveyed code are higher than their rankings for the key reference service code except for the Technical Skill/Physical Effort "physical effort required" value.

Recommending the median work RVU for the surveyed code that is higher than the key reference service code is further supported by the fact that CPT standard for reporting 99231 is higher than the 99347 CPT reporting standard. While the history and examination components are identical, 99231 has a higher medical decision making upper limit and the physician must meet all the three key components instead of the two required for 99347.

Further, we have identified compelling evidence outside the survey, described below, to supplement our recommended work RVU for this code.

Additional Documentation

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed because the physician work surveys were conducted in 1995. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation in the previous five years. These urvey results were published in the December 2002 Journal of Clinical Oncology article "the American Society of Clinical Oncology 2001 Presidential Initiative: Impact of Regulatory Burden on Quality Cancer Care," by Lawrence Einhorn et al.

The E/M documentation requirements add to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The advent of electronic databases, while facilitating access to patient information, has created new work for clinicians. Medication and problem lists must be accurately maintained by providers. Further, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

Increased Intensity

Reduced Hospital Length of Stay

Hospital length of stay has decreased in the last ten years. According to Medicare data provided by CMS, in 1990, the average length of stay in all short-stay hospitals was 9.0 days. In 2001, the corresponding length of stay was 6.0 days.

The 2003 National Hospital Discharge Survey data published by the Centers for Disease Control and Prevention on July 8, 2005 provide hospital length of stay information for all inpatients in the United States (Medicare and all non Medicare):

- The average length of stay decreased from 6.4 days in 1990 to 4.8 days in 2003;
- The percentage of patients with an inpatient stay of 8 days or more decreased from approximately 26% in 1990 to 16% in 2003; and
- The percentage of patients with an inpatient stay of 3 days or less increased from approximately 46% in 1990 to 57% in 2003

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Shortened length of stay result in increased intensity of subsequent hospital care visits.

Adherence to Evidence-Based Hospital Care Processes Performance Measures

Efforts that track hospital adherence to evidence based care processes that encourage improvement in their quality of care have resulted in physicians being more proactive in treating inpatients. The article "Quality of Care in U.S. Hospitals as Reflected by Standardized Measures, 2002-2004, written by Scott Williams et al, in the July 21, 2005 New England Journal of Medicine, describes consistent improvement in measures reflecting the processes of care for acute myocardial infraction, heart failure, and pneumonia. The study described in the article examined how hospitals performed on 17 standard care process measures implemented by the Joint Commission on Accreditation of Healthcare Organizations in July 2002. The study involved data collected from over 3,000 accredited hospitals over a two-year period. Using the first quarter in which data was reported as a baseline, the hospitals improved significantly in 15 of 17 care process measures, with no measure showing a significant deterioration, over the two-year period.

Selected process measures that pertaining to subsequent hospital care services for which hospitals showed significant improvement are:

Acute Myocardial Infarction

- Smoking cessation counseling or advice

Heart Failure

- Assessment of left ventricular function
- Smoking cessation counseling or advice

Pneumonia

- Pneumococcal screening, vaccination, or both by discharge
- Blood cultures collected by initiation of antibiotic therapy
- Smoking cessation counseling or advice

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVUs for this code from 1.06 to 2.00, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 61% No 38%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 97% less complex (less work) 0% no change 3%
C. The usual site-of-service has changed:
   from outpatient to inpatient 8% from inpatient to outpatient 24% no change 68%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99232 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **2.02**
RUC RVU: **1.30**

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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent hospital visit for a 63-year-old male with Type 2 diabetes mellitus, diabetic neuropathy and nephropathy, hypertension, and hyperlipidemia, who was admitted with a diabetic foot infection and hyperglycemia, is seen for subsequent hospital care. The patient continues to be febrile with no improvement in his foot despite parenteral antibiotics.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family

Description of Intra-Service Work:
- Review medical records and data available on the unit
- Obtain a problem focused history*
- Perform a problem focused physical exam*
- Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) (straightforward or low complexity medical decision making)*
- Discuss diagnosis and treatment options with the patient and/or family
- Consider discharge needs of patient
- Communicate with other health care professionals
- Write/review orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family

* Two of these three components required

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Larry Martinelli, M.D. (IDSA)

Specialty(s):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Osteopathic Association, Infectious Diseases Society of America, The Endocrine Society, Infectious Disease Society of America
CPT Code:	99232

Sample Size:	3710	**Resp n:** 60	**Response:** 1.61 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	1.50	**2.02**	3.10	11 00
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	15.00	**20.00**	25.00	40.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99235	XXX	3.41

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
71275	XXX	1.92

CPT Descriptor 1 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

MPC CPT Code 2	Global	Work RVU
99387	XXX	2.06

CPT Descriptor 2 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 65 years and over

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 16.6 %

TIME ESTIMATES (Median)	CPT Code: 99232	Key Reference CPT Code: 99235
Median Pre-Service Time	10.00	10.00
Median Intra-Service Time	20.00	75.00
Median Immediate Post-service Time	10.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**40.00**	**100.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.46	3.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.78
Urgency of medical decision making	3.42	3.67

Technical Skill/Physical Effort (Mean)

Technical skill required	3.53	3.78
Physical effort required	3.04	3.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.56
Outcome depends on the skill and judgment of physician	3.60	3.89
Estimated risk of malpractice suit with poor outcome	3.59	3 78

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.08	3.44
Intra-Service intensity/complexity	3 54	3.56
Post-Service intensity/complexity	3.29	3.56

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

90% of survey respondents indicated that they believe the work associated with this code has changed in the last five ears-with nearly every respondent who stated that the work has increased selecting the patients are "more complex (more work)" option as a contributing factor.

76% of respondents indicated that the vignette describes their typical patient.

Approximately 17% of respondents selected 99235 as the key reference service code. Respondents' choice of key reference service was diffuse because the high number of E/M service codes included in the Five-Year limited the number of E/M code-the most logical choice for a direct comparison of work-available as reference codes. Respondents most frequently selected a code in the 99235 as it allowed them to directly compare inpatient work. The current key eference service work RVU of 3.41 is higher than the current surveyed code work RVU and the respondents' median work RVU for the surveyed code. Accordingly, all the survey respondents' intensity/complexity measure rankings for the key reference service code are higher than their rankings for the surveyed code.

Further, we have identified compelling evidence outside the survey, described below, to supplement our recommended work RVU for this code.

Additional Documentation

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed because the physician work surveys were conducted in 1995. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation in the previous five years. These survey results were published in the December 2002 Journal of Clinical Oncology article "the American Society of Clinical Oncology 2001 Presidential Initiative: Impact of Regulatory Burden on Quality Cancer Care," by Lawrence Einhorn et al.

The E/M documentation requirements add to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The advent of electronic databases, while facilitating access to patient information, has created new work for clinicians. Medication and problem lists must be accurately maintained by providers. Further, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

Increased Intensity

Reduced Hospital Length of Stay

Hospital length of stay has decreased in the last ten years. According to Medicare data provided by CMS, in 1990, the average length of stay in all short-stay hospitals was 9.0 days. In 2001, the corresponding length of stay was 6.0 days.

The 2003 National Hospital Discharge Survey data published by the Centers for Disease Control and Prevention on July 8, 2005 provide hospital length of stay information for all inpatients in the United States (Medicare and all non Medicare):

- The average length of stay decreased from 6.4 days in 1990 to 4.8 days in 2003;
- The percentage of patients with an inpatient stay of 8 days or more decreased from approximately 26% in 1990 to 16% in 2003; and
- The percentage of patients with an inpatient stay of 3 days or less increased from approximately 46% in 1990 to 57% in 2003

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Shortened length of stay result in increased intensity of subsequent hospital care visits.

Adherence to Evidence-Based Hospital Care Processes Performance Measures

Efforts that track hospital adherence to evidence based care processes that encourage improvement in their quality of care have resulted in physicians being more proactive in treating inpatients. The article "Quality of Care in U.S. Hospitals as Reflected by Standardized Measures, 2002-2004, written by Scott Williams et al, in the July 21, 2005 New England Journal of Medicine, describes consistent improvement in measures reflecting the processes of care for acute myocardial infraction, heart failure, and pneumonia. The study described in the article examined how hospitals performed on 17 standard care process measures implemented by the Joint Commission on Accreditation of Healthcare Organizations in July 2002. The study involved data collected from over 3,000 accredited hospitals over a two-year period. Using the first quarter in which data was reported as a baseline, the hospitals improved significantly in 15 of 17 care process measures, with no measure showing a significant deterioration, over the two-year period.

Selected process measures that pertaining to subsequent hospital care services for which hospitals showed significant improvement are:

Acute Myocardial Infarction

- Smoking cessation counseling or advice

Heart Failure

- Assessment of left ventricular function
- Smoking cessation counseling or advice

Pneumonia

- Pneumococcal screening, vaccination, or both by discharge
- Blood cultures collected by initiation of antibiotic therapy
- Smoking cessation counseling or advice

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVUs for this code from 1.06 to 2.00, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and

accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 90% No 10%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 1% I do not agree 99%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 5% from inpatient to outpatient 20% no change 75%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99233 Global Period: XXX Specialty Society RVU: **3.03**

RUC RVU: **2.00**

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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent hospital visit for a 75-year-old female admitted with cellulitis around a right great toe ulcer. She has Type 2 diabetes mellitus, ischemic cardiomyopathy, atherosclerotic peripheral vascular disease, hypertension, and chronic renal insufficiency. Her cellulitis is better, but non-invasive blood flow measurements show significantly reduced flow to the foot, blood sugars are over 200, and she is newly delirious

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:

Review data not available on the unit (e.g. diagnostic and imaging studies)

- Communicate with other professionals and with patient or patient's family

Description of Intra-Service Work:

- Review medical records and data available on the unit
- Obtain a problem focused history*
- Perform a problem focused physical exam*
- Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) (straightforward or low complexity medical decision making)*
- Discuss diagnosis and treatment options with the patient and/or family
- Consider discharge needs of patient
- Communicate with other health care professionals
- Write/review orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:

- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family

* Two of these three components required

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Larry Martinelli, M.D. (IDSA)

Specialty(s):	American Academy of Family Physicians, American Academy of Neurology, American College of Physicians, American Osteopathic Association, Infectious Diseases Society of America, The Endocrine Society, Infectious Disease Society of America
CPT Code:	99233

Sample Size:	3710	**Resp n:** 60	**Response:** 1.61 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	2.00	**3.03**	4.26	15.00
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	20.00	**25.00**	35 00	60 00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three components: a comprehensive history, a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99440	XXX	2.93

CPT Descriptor 1 Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

MPC CPT Code 2	Global	Work RVU
77427	XXX	3.31

CPT Descriptor 2 Radiation treatment management, five treatments

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 12 **% of respondents:** 20.0 %

TIME ESTIMATES (Median)	CPT Code: 99233	Key Reference CPT Code: 99236
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	25.00	110.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0 00
Median Total Time	**50.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.67	4.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.72	4.82
Urgency of medical decision making	4.67	4.55

Technical Skill/Physical Effort (Mean)

Technical skill required	4.66	4.82
Physical effort required	3.98	4.09

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.74	4.64
Outcome depends on the skill and judgment of physician	4.65	4.73
Estimated risk of malpractice suit with poor outcome	4.33	4.64

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.26	4 18
Intra-Service intensity/complexity	4.76	4.55
Post-Service intensity/complexity	4.48	4.55

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Approximately 92% of survey respondents indicated that they believe the work associated with this code has changed in ıe last five years–with nearly every respondent who stated that the work has increased selecting the patients are "more complex (more work)" option as a contributing factor.

85% of respondents indicated that the vignette describes their typical patient.

Approximately 17% of respondents selected 99236 as the key reference service code. Respondents' choice of key reference service was diffuse because the high number of E/M service codes included in the Five-Year limited the number of E/M code the most logical choice for a direct comparison of work available as reference codes. Respondents most frequently selected a code in the 99236 as it allowed them to directly compare inpatient work. The current key reference service work RVU of 4.26 is higher than the respondents' median work RVU for the surveyed code of 3.00. The increase represented by surveyed code median work RVU is supported by the fact that respondents' intensity/complexity measure values were higher for the surveyed code for four of the 11 measures: the Mental Effort and Judgment "urgency of medical decision making" value; the Psychological Stress "risk of significant complications, morbidity, and/or mortality" value; the Time Segments "pre-service intensity/complexity" value; and the Time Segments "intra-service intensity/complexity" value.

Further, we have identified compelling evidence outside the survey, described below, to supplement our recommended work RVU for this code.

Additional Documentation

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed because the physician work surveys were conducted in 1995. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation in the previous five years. These survey results were published in the December 2002 Journal of Clinical Oncology article "the American Society of Clinical Oncology 2001 Presidential Initiative: Impact of Regulatory Burden on Quality Cancer Care," by Lawrence Einhorn et al.

The E/M documentation requirements add to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The advent of electronic databases, while facilitating access to patient information, has created new work for clinicians. Medication and problem lists must be accurately maintained by providers. Further, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

Increased Intensity

Reduced Hospital Length of Stay

Hospital length of stay has decreased in the last ten years. According to Medicare data provided by CMS, in 1990, the average length of stay in all short-stay hospitals was 9.0 days. In 2001, the corresponding length of stay was 6.0 days.

The 2003 National Hospital Discharge Survey data published by the Centers for Disease Control and Prevention on July 8, 2005 provide hospital length of stay information for all inpatients in the United States (Medicare and all non Medicare):

- The average length of stay decreased from 6.4 days in 1990 to 4.8 days in 2003;
- The percentage of patients with an inpatient stay of 8 days or more decreased from approximately 26% in 1990 to 16% in 2003; and
- The percentage of patients with an inpatient stay of 3 days or less increased from approximately 46% in 1990 to 57% in 2003

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

hortened length of stay result in increased intensity of subsequent hospital care visits.

Adherence to Evidence-Based Hospital Care Processes Performance Measures

Efforts that track hospital adherence to evidence based care processes that encourage improvement in their quality of care have resulted in physicians being more proactive in treating inpatients. The article "Quality of Care in U S Hospitals as Reflected by Standardized Measures, 2002-2004, written by Scott Williams et al, in the July 21, 2005 New England Journal of Medicine, describes consistent improvement in measures reflecting the processes of care for acute myocardial infraction, heart failure, and pneumonia. The study described in the article examined how hospitals performed on 17 standard care process measures implemented by the Joint Commission on Accreditation of Healthcare Organizations in July 2002. The study involved data collected from over 3,000 accredited hospitals over a two-year period. Using the first quarter in which data was reported as a baseline, the hospitals improved significantly in 15 of 17 care process measures, with no measure showing a significant deterioration, over the two-year period

Selected process measures that pertaining to subsequent hospital care services for which hospitals showed significant improvement are:

Acute Myocardial Infarction

- Smoking cessation counseling or advice

Heart Failure

- Assessment of left ventricular function
- Smoking cessation counseling or advice

Pneumonia

- Pneumococcal screening, vaccination, or both by discharge
- Blood cultures collected by initiation of antibiotic therapy
- Smoking cessation counseling or advice

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVUs for this code from 1.51 to 3.00, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions. No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 91% No 10%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 1% I do not agree 99%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 7% from inpatient to outpatient 20% no change 73%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra ssist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99238 | Global Period: XXX | **Recommended Work Relative Value** Specialty Society RVU: **1.50** RUC RVU: **1.28**

CPT Descriptor. Hospital discharge day management: 30 minutes or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Discharge visit for a 55-year-old male admitted with a community-acquired pneumonia is seen in preparation for discharge from the hospital. He is euvolemic, afebrile, asymptomatic, and his oxygen saturations are normal

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family

Description of Intra-Service Work:
- Review medical records and data available on the unit
- Obtain an interval history
- Perform a physical exam
- Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) including making the decision for discharge
- Discuss aftercare treatment with the patient, family and other healthcare professionals
- Provide care coordination for the transition including instructions for aftercare to caregivers
- Order/arrange for post discharge follow-up professional services and testing
- Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write prescriptions
- Complete discharge and aftercare forms
- Inform the primary care or referring physician of discharge plans
- Complete medical record documentation

Description of Post-Service Work:
- Complete discharge records
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after discharge
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this hospitalization
- Receive and respond to any interval testing results or correspondence, including obtaining any results pending at discharge
- Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Doug Leahy, M.D. (ACP)

Specialty(s):	American Academy of Family Physicians, American College of Physicians, American Osteopathic Association				
CPT Code:	99238				
Sample Size:	615	**Resp n:** 40	**Response:** 6.50 %		
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	1.33	**1.50**	2.50	5.40
Pre-Service Evaluation Time:			**9.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	15.00	**20.00**	25 00	45.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63), 99292 (32); 99233 (41); 99232 (30); 99231 (19), 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99235	XXX	3 41

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three components: a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
88173	XXX	1.39

CPT Descriptor 1 Cytopathology, evaluation of fine needle aspirate; interpretation and report

MPC CPT Code 2	Global	Work RVU
99385	XXX	1.53

CPT Descriptor 2 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 5 **% of respondents:** 12.5 %

TIME ESTIMATES (Median)	**CPT Code: 99238**	**Key Reference CPT Code: 99235**
Median Pre-Service Time	9.00	10.00
Median Intra-Service Time	20.00	75.00
Median Immediate Post-service Time	10.00	15 00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**39.00**	**100.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.10	3.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	3.60
Urgency of medical decision making	2.90	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	4.00
Physical effort required	2.40	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.10	4.00
Outcome depends on the skill and judgment of physician	3.50	4.40
Estimated risk of malpractice suit with poor outcome	3.40	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	3.80
Intra-Service intensity/complexity	3.30	3.80
Post-Service intensity/complexity	2.90	3.80

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

80% of survey respondents indicated that they believe the work associated with this code has changed in the last five years with all but one respondent who stated that the work has increased selecting the patients are "more complex (more work)" option as a contributing factor.

90% of respondents indicated that the vignette describes their typical patient.

Approximately 13% of respondents selected 99235 as the key reference service code. Respondents' choice of key reference service was diffuse because the high number of E/M service codes included in the Five-Year limited the number of E/M code-the most logical choice for a direct comparison of work-available as reference codes. Respondents most frequently selected a code in the 99235 as it allowed them to directly compare inpatient work. The current key reference service code work RVU of 3.41 is higher than the respondents' median work RVU for the surveyed code of 1.50. Accordingly, all the survey respondents' intensity/complexity measure rankings for the key reference service code are higher than their rankings for the surveyed code.

Further, we have identified compelling evidence outside the survey, described below, to supplement our recommended work RVU for this code.

Additional Documentation

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed because the physician work surveys were conducted in 1995. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation in the previous five years. These survey results were published in the December 2002 Journal of Clinical Oncology article "the American Society of Clinical Oncology 2001 Presidential Initiative: Impact of Regulatory Burden on Quality Cancer Care," by Lawrence Einhorn et al.

The E/M documentation requirements add to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The advent of electronic databases, while facilitating access to patient information, has created new work for clinicians. Medication and problem lists must be accurately maintained by providers. Further, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

Increased Intensity; Reduced Hospital Length of Stay

Hospital length of stay has decreased in the last ten years. According to Medicare data provided by CMS, in 1990, the average length of stay in all short-stay hospitals was 9.0 days. In 2001, the corresponding length of stay was 6.0 days.

The 2003 National Hospital Discharge Survey data published by the Centers for Disease Control and Prevention on July 8, 2005 provide hospital length of stay information for all inpatients in the United States (Medicare and all non Medicare):

- The average length of stay decreased from 6.4 days in 1990 to 4.8 days in 2003;
- The percentage of patients with an inpatient stay of 8 days or more decreased from approximately 26% in 1990 to 16% in 2003, and
- The percentage of patients with an inpatient stay of 3 days or less increased from approximately 46% in 1990 to 57% in 2003

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Shortened length of stay results in increased intensity of hospital discharge services.

Adherence to Evidence-Based Hospital Care Processes Performance Measures

Efforts that track hospital adherence to evidence based care processes that encourage improvement in their quality of are have resulted in physicians being more proactive in treating inpatients. The article "Quality of Care in U.S. Hospitals as Reflected by Standardized Measures, 2002-2004, written by Scott Williams et al, in the July 21, 2005 New England Journal of Medicine, describes consistent improvement in measures reflecting the processes of care for acute myocardial infraction, heart failure, and pneumonia.' The study described in the article examined how hospitals performed on 17 standard care process measures implemented by the Joint Commission on Accreditation of Healthcare Organizations in July 2002. The study involved data collected from over 3,000 accredited hospitals over a two-year period. Using the first quarter in which data was reported as a baseline, the hospitals improved significantly in 15 of 17 care process measures, with no measure showing a significant deterioration, over the two-year period.

Selected process measures that pertaining to hospital discharge services for which hospitals showed significant improvement are

Acute Myocardial Infarction

- Aspirin prescribed at discharge
- ACE inhibitor prescribed at discharge for patients with left ventricular systolic dysfunction
- Beta blocker prescribed at discharge

Heart Failure

- Discharge instructions regarding medications, diet, weight, worsening of symptoms, follow-up, and activity
- ACE inhibitor prescribed at discharge for patients with left ventricular systolic dysfunction

'neumonia

- Pneumococcal screening, vaccination, or both by discharge
- Blood cultures collected by initiation of antibiotic therapy

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVUs for this code from 1.28 to 1.50, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 80% No 20%

A. This service represents new technology that has become more familiar (i.e., less work).
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 9% from inpatient to outpatient 34% no change 57%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type.	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code 99239 | Global Period: XXX | **Recommended Work Relative Value** Specialty Society RVU: **2.30** RUC RVU: **1.90**

CPT Descriptor: Hospital discharge day management: more than 30 minutes

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Discharge visit for a 75-year-old female who required a below-the knee amputation for an infected non-healing ulcer on her right foot is seen in preparation for discharge from the hospital. She has Type 2 diabetes mellitus, ischemic cardiomyopathy, atherosclerotic peripheral vascular disease, hypertension, chronic renal insufficiency, and dementia. She is no longer delirious, her blood sugars are well controlled, and she is at her baseline weight. She is being discharged back to the nursing home.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family

Description of Intra-Service Work:
Review medical records and data available on the unit
- Obtain an interval history
- Perform a physical exam
- Consider relevant data, options, and risks and formulate/revise diagnosis and treatment plan(s) including making the decision for discharge
- Discuss aftercare treatment with the patient, family and other healthcare professionals
- Provide care coordination for the transition including instructions for aftercare to caregivers
- Order/arrange for post discharge follow-up professional services and testing
- Reconcile medications with attention to pre-admission therapy, inpatient therapy and outpatient formulary and write prescriptions
- Complete discharge and aftercare forms
- Inform the primary care or referring physician of discharge plans
- Complete medical record documentation

Description of Post-Service Work:
- Complete discharge records
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after discharge
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this hospitalization
- Receive and respond to any interval testing results or correspondence, including obtaining any results pending at discharge
- Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005

Presenter(s)	Doug Leahy, M.D. (ACP)
Specialty(s):	American Academy of Family Physicians, American College of Physicians, American Osteopathic Association
CPT Code:	99239

Sample Size:	615	**Resp n:** 40	**Response:** 6.50 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	1.90	**2.30**	3.50	6.20
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	15.00	20.00	**30.00**	36.30	80.00

Post-Service	Total Min**	CPT code / # of visits
Immed Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41); 99232 (30); 99231 (19), 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers consistent with the nature of the problem(s) and the patient's and/or family's needs Usually the presenting problem(s) requiring admission are of high severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
93312	XXX	2.20

CPT Descriptor 1 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

MPC CPT Code 2	Global	Work RVU
99298	XXX	2.75

CPT Descriptor 2 Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams)

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 17.5 %

TIME ESTIMATES (Median)	**CPT Code: 99239**	**Key Reference CPT Code: 99236**
Median Pre-Service Time	10.00	0.00
Median Intra-Service Time	30.00	110.00
Median Immediate Post-service Time	15.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**55.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.40	4.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.80	4.60
Urgency of medical decision making	3.90	4.40

Technical Skill/Physical Effort (Mean)

Technical skill required	4.10	4.40
Physical effort required	3.30	3.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.40	4.70
Outcome depends on the skill and judgment of physician	4.50	4.70
Estimated risk of malpractice suit with poor outcome	4.20	4.30

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	3.80	4.00
Intra-Service intensity/complexity	4.40	4.60
Post-Service intensity/complexity	4.00	4.40

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Approximately 98% of survey respondents indicated that they believe the work associated with this code has changed in the last five years–with every respondent who stated that the work has increased selecting the patients are "more complex (more work)" option as a contributing factor.

Approximately 98% of respondents indicated that the vignette describes their typical patient.

Approximately 18% of respondents selected 99236 as the key reference service code. Respondents' choice of key reference service was diffuse because the high number of E/M service codes included in the Five-Year limited the number of E/M code the most logical choice for a direct comparison of work available as reference codes. Respondents most frequently selected a code in the 99236 as it allowed them to directly compare inpatient work. The current key reference service code work RVU of 4.26 is higher than the respondents' median work RVU for the surveyed code of 2.30. All survey respondents' intensity/complexity measure rankings for the key reference service code are higher than their rankings for the surveyed code except from their Mental Effort and Judgment "amount/complexity of medical records" value. The amount by which the key reference service intensity/complexity measures ranking values exceed the surveyed code values is less in this comparison than amount by which key reference service 99235 exceed the surveyed code 99238 values.

Further, we have identified compelling evidence outside the survey, described below, to supplement our recommended work RVU for this code.

Additional Documentation

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed because the physician work surveys were conducted in 1995. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation in the previous five years. These survey results were published in the December 2002 Journal of Clinical Oncology article "the American Society of Clinical Oncology 2001 Presidential Initiative: Impact of Regulatory Burden on Quality Cancer Care," by Lawrence Einhorn et al.

The E/M documentation requirements add to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The advent of electronic databases, while facilitating access to patient information, has created new work for clinicians Medication and problem lists must be accurately maintained by providers. Further, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for quality care.

Increased Intensity, Reduced Hospital Length of Stay

Hospital length of stay has decreased in the last ten years. According to Medicare data provided by CMS, in 1990, the average length of stay in all short-stay hospitals was 9.0 days. In 2001, the corresponding length of stay was 6.0 days.

The 2003 National Hospital Discharge Survey data published by the Centers for Disease Control and Prevention on July 8, 2005 provide hospital length of stay information for all inpatients in the United States (Medicare and all non Medicare):

- The average length of stay decreased from 6.4 days in 1990 to 4.8 days in 2003;
- The percentage of patients with an inpatient stay of 8 days or more decreased from approximately 26% in 1990 to 16% in 2003, and
- The percentage of patients with an inpatient stay of 3 days or less increased from approximately 46% in 1990 to 57% in 2003

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Shortened length of stay results in increased intensity of hospital discharge services.

Adherence to Evidence-Based Hospital Care Processes Performance Measures

Efforts that track hospital adherence to evidence based care processes that encourage improvement in their quality of care have resulted in physicians being more proactive in treating inpatients. The article "Quality of Care in U.S. Hospitals as Reflected by Standardized Measures, 2002-2004, written by Scott Williams et al, in the July 21, 2005 New England Journal of Medicine, describes consistent improvement in measures reflecting the processes of care for acute myocardial infraction, heart failure, and pneumonia. The study described in the article examined how hospitals performed on 17 standard care process measures implemented by the Joint Commission on Accreditation of Healthcare Organizations in July 2002. The study involved data collected from over 3,000 accredited hospitals over a two-year period. Using the first quarter in which data was reported as a baseline, the hospitals improved significantly in 15 of 17 care process measures, with no measure showing a significant deterioration, over the two-year period.

Selected process measures that pertaining to hospital discharge services for which hospitals showed significant improvement are

Acute Myocardial Infarction

- Aspirin prescribed at discharge
- ACE inhibitor prescribed at discharge for patients with left ventricular systolic dysfunction
- Beta blocker prescribed at discharge

Heart Failure

- Discharge instructions regarding medications, diet, weight, worsening of symptoms, follow-up, and activity
- ACE inhibitor prescribed at discharge for patients with left ventricular systolic dysfunction

Pneumonia

- Pneumococcal screening, vaccination, or both by discharge
- Blood cultures collected by initiation of antibiotic therapy

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVUs for this code from 1.75 to 2.30, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 97% No 2%

A. This service represents new technology that has become more familiar (i.e., less work):
I agree 0% I do not agree 100%
B. Patients requiring this service are now:
more complex (more work) 100% less complex (less work) 0% no change
C. The usual site-of-service has changed:
from outpatient to inpatient 7% from inpatient to outpatient 34% no change 59%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99241 Global Period: XXX Specialty Society RVU: **1.00**

RUC RVU: **0.64**

CPT Descriptor: Office 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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 21-year old female was seen for office consultation for rectal bleeding. She has had prior sigmoidoscopy within 1 year which showed only internal hemorrhoids, has recently become constipated and straining and saw scant blood on the tissue.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review referral records
- Review the medical history form completed by the patient and vital signs obtained by clinical staff
  Communicate with other health professionals

Description of Intra-Service Work:
- Obtain a problem focused history
- Perform a problem focused examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (straightforward medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Write prescription(s), order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary
- Provide ongoing consultation to referring healthcare professional

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	James Anthony, M.D. (AAN)

Specialty(s):	American Academy of Neurology, American Association of Clinical Endocrinologists, American College of Physicians, American Osteopathic Association, American College of Rheumatology, American Society of Clinical Oncology, and American Society of Hematology

CPT Code: 99241

Sample Size:	4784	**Resp n:** 94		**Response:** 1.96 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0 17	0.70	**1.00**	1 50	200.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	10.00	**15.00**	18 50	45.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**5.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41), 99232 (30), 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7)

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
9347	XXX	0.76

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three components: a problem focused interval 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 15 minutes face-to-face with the patient and/or family.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review

MPC CPT Code 1	Global	Work RVU
78472	XXX	.98

CPT Descriptor 1 Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing

MPC CPT Code 2	Global	Work RVU
31575	XXX	1.1

CPT Descriptor 2 Laryngoscopy, flexible fiberoptic; diagnostic

Other Reference CPT Code	Global	Work RVU
	XXX	

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 7 **% of respondents:** 7.4 %

TIME ESTIMATES (Median)	CPT Code: 99241	Key Reference CPT Code: 99347
Median Pre-Service Time	5 00	5.00
Median Intra-Service Time	15.00	15.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**25.00**	**30.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	1.70	1.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.70	1.40
Urgency of medical decision making	1.80	1.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.10	1.50
Physical effort required	1.70	1.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.80	1.00
Outcome depends on the skill and judgment of physician	2.30	1.80
Estimated risk of malpractice suit with poor outcome	2 40	1.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.40	1.30
Intra-Service intensity/complexity	1.70	1.60
Post-Service intensity/complexity	1.40	1.30

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Over 52% of respondents indicated that they believe the work associated with this code has changed in the last five years. Although 52% represents a majority, we believe the response to this question would have been higher if the respondents were aware that this code has not been reviewed since the first Five-Year Review, approximately 10 years ago. Further, survey respondents' median work RVU for this code is 1.00 and the 25th percentile is 0.70, which are both above the current work RVU of 0.64 indicating that many respondents who stated that the work has not changed in the past five years, in fact, believe the work current RVU is undervalued. Seventy-one percent of respondents stated the

vignette is typical. Respondents rated the complexity/intensity measures higher for the survey code than for the reference code in every category.

We also think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code. There are additional documentation requirements added to physician work. As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines

Because of this compelling evidence and survey respondents' indication that the current work has changed and is undervalued, we are recommending an increase in the work RVU for this code from 0.64 to 1.00, the median of our survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions. No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%)

Has the work of performing this service changed in the past 5 years? Yes 52% No 47%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 4% I do not agree 96%
B. Patients requiring this service are now:
   more complex (more work) 87% less complex (less work) 0% no change 13%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 37% no change 63%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99242 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **1.58**
RUC RVU: **1.34**

CPT Descriptor: Office 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 patients 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

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year old male is seen for office consultation for heartburn. He is otherwise healthy but describes episodic burning substernal pain with typical provocative meals, eating late of excessive coffee. He experiences relief with antacids and has no symptoms suggesting serious disease.

Percentage of Survey Respondents who found Vignette to be Typical. 72%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review referral records
- Review the medical history form completed by the patient and vital signs obtained by clinical staff
  Communicate with other health professionals

Description of Intra-Service Work:
- Obtain a expanded history
- Perform a expanded examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (straightforward medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Write prescription(s), order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary
- Provide ongoing consultation to referring healthcare professional

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s).	James Anthony, M.D. (AAN)

Specialty(s):	American Academy of Neurology, American Association of Clinical Endocrinologists, American College of Physicians, American Osteopathic Association, American College of Rheumatology, American Society of Clinical Oncology, and American Society of Hematology
CPT Code:	99242

Sample Size:	4784	**Resp n:** 94	**Response:** 1.96 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.50	1.34	**1.58**	2.22	250.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	5.00	15.00	**25.00**	30.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99387	XXX	2.06

CPT Descriptor Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 65 years and over

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99385	XXX	1.53

CPT Descriptor 1 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 18-39 years

MPC CPT Code 2	Global	Work RVU
99375	XXX	1.73

CPT Descriptor 2 Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purpose of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

Other Reference CPT Code	Global	Work RVU
99341	XXX	1.01

CPT Descriptor 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 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 20 minutes face-to-face with the patient and/or family

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 4.2 %

TIME ESTIMATES (Median)	CPT Code: 99242	Key Reference CPT Code: 99387
Median Pre-Service Time	5.00	5.00
Median Intra-Service Time	25.00	45.00

Median Immediate Post-service Time	10.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**40.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.50	2.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.60	2.25
Urgency of medical decision making	2.50	1.75

Technical Skill/Physical Effort (Mean)

Technical skill required	2.50	2.25
Physical effort required	2.10	1.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.50
Outcome depends on the skill and judgment of physician	3 00	3.00
Estimated risk of malpractice suit with poor outcome	2 90	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	1.90	2.00
Intra-Service intensity/complexity	2.50	2.00
Post-Service intensity/complexity	2.00	1.80

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Over 60% of respondents indicated that they believe the work associated with this code has changed in the last five ears. Although 60% represents a solid majority, we believe the response to this question would have been higher if the respondents were aware that this code has not been reviewed since the first Five-Year Review, approximately 10 years ago. Further, survey respondents' median work RVU for this code is 1.58 and the 25th percentile is 1.34, which are both above the current work RVU of 1.29-indicating that many respondents who stated that the work has not changed in the past five years, in fact, believe the work current RVU is undervalued. Seventy-two percent of respondents stated the vignette is typical. Respondents rated the intensity/complexity for the survey code as higher for 7 of the measures and similar to the reference code on two measures.

We also think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code. There are more informed patients who want to and should be actively involved in decision-making, and they bring more information with them to their visits. These patients are presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press. As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than it did ten years ago when E/M codes were last reviewed. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

Other compelling evidence for a change in work for this code is the additional documentation requirements added to physician work. As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines.

Because of this compelling evidence and survey respondents' indication that the current work has changed and is ndervalued, we are recommending an increase in the work RVU for this code from 1.29 to 1.58, the median of our survey.

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SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 60% No 39%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
   from outpatient to inpatient 0% from inpatient to outpatient 34% no change 66%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type.	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99243 | Global Period: XXX | **Recommended Work Relative Value** Specialty Society RVU: **2.01** RUC RVU: **1.88**

CPT Descriptor: Office 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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 24-year old male is seen for office consultation for throbbing headaches associated with nausea. Headaches are throbbing in character and usually, but not always, associated with visual "floaters" in the left visual field. These headaches occur usually 2-3 times a month and are precipitated by sleep deprivation or red wine.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review referral records
- Review the medical history form completed by the patient and vital signs obtained by clinical staff
- Communicate with other health professionals

Description of Intra-Service Work:
- Obtain a detailed history
- Perform a detailed examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (low complexity medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Write prescription(s), order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary
- Provide ongoing consultation to referring healthcare professional

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	James Anthony, M.D. (AAN)

Specialty(s):	American Academy of Neurology, American Association of Clinical Endocrinologists, American College of Physicians, American Osteopathic Association, American College of Rheumatology, American Society of Clinical Oncology, and American Society of Hematology

CPT Code: 99243

Sample Size:	4784	**Resp n:** 94		**Response:** 1.96 %	
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	1.97	**2.01**	3.00	300.00
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	25.00	**35.00**	40.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32), 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99386	XXX	1.88

CPT Descriptor Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient; 40-64 years

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
71275	XXX	1.92

CPT Descriptor 1 Computed tomographic angiography, chest, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

MPC CPT Code 2	Global	Work RVU
93312	XXX	2.20

CPT Descriptor 2 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 6 **% of respondents:** 6.3 %

TIME ESTIMATES (Median)	CPT Code: 99243	Key Reference CPT Code: 99386
Median Pre-Service Time	10.00	5.00
Median Intra-Service Time	35.00	40.00
Median Immediate Post-service Time	10.00	10.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**55.00**	**55.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.30	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.00
Urgency of medical decision making	3.30	2.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.30	2.50
Physical effort required	2.80	2.30

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.00
Outcome depends on the skill and judgment of physician	3.70	3.00
Estimated risk of malpractice suit with poor outcome	3.50	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.80	2.60
Intra-Service intensity/complexity	3.30	2.80
Post-Service intensity/complexity	3.00	2.80

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Eighty-four percent of respondents indicated that they believe the work associated with this code has changed in the last ve years. Eighty-one percent of respondents stated the vignette is typical. Respondents rated the complexity/intensity measures higher for the survey code than for the reference code in every category.

We also think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code. For instance, there is a greater expectation that physicians will be proactive in disease prevention and diagnosing and

treating illness. Physicians must be more opportunistic in addressing prevention. This need to be opportunistic is reinforced by the growing emphasis on ambulatory quality measures and pay-for-performance programs that focus on such measures.

At the same time, there has been an increase in the complexity of data to be evaluated and care to be managed at such follow-up visits Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intraservice intensity of E/M services and increases the pre- and post-service time involved. There is also more polypharmacy and an explosion in the number of clinical guidelines that are good examples of what is considered optimal care. Add to this all of the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions (e.g., hypertension and hyperlipidemia) has increased.

Similarly, there are more informed patients who want to and should be actively involved in decision-making, and they bring more information with them to their visits. These patients are presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press. As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than it did ten years ago when E/M codes were last reviewed. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

Other compelling evidence for a change in work for this code is the additional documentation requirements added to physician work As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines.

There is also the greater role that genomics plays in the evaluation and potential management of patients. Ten years ago, the human genome had not been mapped. Now, it has. With the mapping and sequencing of the human genome, medical professionals from essentially all specialties have turned their attention to investigating the role genes play in health and disease, and genetic disease represents an important part of medical practice. Diagnosing a genetic disorder not only allows for disease-specific management options but also has implications for the affected individual's entire family. As such, a working understanding of the underlying concepts of genetic disease is necessary for today's practicing physician, and routine clinical practice requires integration of these fundamental concepts for use in accurate diagnosis and ensuring appropriate referrals for patients with genetic disease and their families. In addition, genomic information will become integral to the selection of treatment in a variety of disease conditions, adding a new dimension to disease management. All of this expands the knowledge base required for each E/M service since this information must be integrated with the traditional cognitive base.

Finally, there is evidence that the intensity of E/M services has increased over time. Support for the increased intensity of E/M services, particularly office visits, may be found in the results of the National Ambulatory Medical Care Survey. Data from this survey published by the Centers for Disease Control and Prevention in 2003 reflect increasing complexity and intensity of physician work in office practice from 1992-2002. Patients were older, had more complex diagnoses, more discussion of treatment and more mention of drugs used in treatment in 2002 than was the case in 1992. This is reinforced by the fact that close to half of the survey respondents cited patients as more complex as a reason the work of this service has changed over the last five years.

Because of this compelling evidence and survey respondents' indication that the current work has changed and is undervalued, we are recommending an increase in the work RVU for this code from 1.72 to 2.00, the median of our survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions. No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%)

Has the work of performing this service changed in the past 5 years? Yes 84% No 16%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
   from outpatient to inpatient 2% from inpatient to outpatient 50% no change 48%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time.			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99244 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **3.02**
RUC RVU: **3.02**

CPT Descriptor. Office 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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey A 60-year old female is seen for office consultation for evaluation for complaints of heart palpitations with occasional dizziness and abdominal pain, with a past history of hypertension, osteoarthritis, and morbid obesity. Past medical history includes total abdominal hysterectomy 15 years previously for dysfunctional uterine bleeding. She has had no follow up for 15 years.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review referral records
  Review the medical history form completed by the patient and vital signs obtained by clinical staff
- Communicate with other health professionals

Description of Intra-Service Work:
- Obtain a comprehensive history
- Perform a comprehensive examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (moderate medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Write prescription(s), order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary
- Provide ongoing consultation to referring healthcare professional

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s)	James Anthony, M.D. (AAN)

Specialty(s):	American Academy of Neurology, American Association of Clinical Endocrinologists, American College of Physicians, American Osteopathic Association, American College of Rheumatology, American Society of Clinical Oncology, and American Society of Hematology
CPT Code:	99244

Sample Size:	4784	**Resp n:** 94	**Response:** 1.96 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.20	2.48	**3.02**	3.79	462.00
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	15.00	35.00	**45.00**	60.00	80.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	15.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99350	XXX	3.03

CPT Descriptor Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive examination; medical decision making of moderate to 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 The patient may be unstable or may have developed a significant problem requiring immediate physician attention Physicians typically spend 60 minutes face-to-face with the patient and/or family

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99440	XXX	2.93

CPT Descriptor 1 Newborn resuscitation: provision or positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

MPC CPT Code 2	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 8 **% of respondents:** 8.5 %

TIME ESTIMATES (Median)	CPT Code: 99244	Key Reference CPT Code: 99350
Median Pre-Service Time	10.00	15.00
Median Intra-Service Time	45.00	75.00
Median Immediate Post-service Time	15.00	20.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**70.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.10	4 40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.30	4.20
Urgency of medical decision making	4.20	4.20

Technical Skill/Physical Effort (Mean)

Technical skill required	4.10	4.00
Physical effort required	3 60	3 20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.20	3.80
Outcome depends on the skill and judgment of physician	4.50	4.80
Estimated risk of malpractice suit with poor outcome	4.10	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.70	3.10
Intra-Service intensity/complexity	4.10	4.40
Post-Service intensity/complexity	4.00	4 10

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Ninety-eight percent of respondents indicated that they believe the work associated with this code has changed in the last ve years. Eighty-four percent of respondents stated the vignette is typical. Respondents chose a key reference code with a work RVU of 3 03, which is very close to the median survey RVU for 99242, at 3.02. The complexity/intensity comparisons were close but split between the survey and reference code, with respondents rating the survey code higher on six measures and a tie on one measure.

We also think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code. For instance, there is a greater expectation that physicians will be proactive in disease prevention and diagnosing and treating illness Physicians must be more opportunistic in addressing prevention. This need to be opportunistic is reinforced by the growing emphasis on ambulatory quality measures and pay-for-performance programs that focus on uch measures

At the same time, there has been an increase in the complexity of data to be evaluated and care to be managed at such follow-up visits Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intraservice intensity of E/M services and increases the pre- and post-service time involved. There is also more polypharmacy and an explosion in the number of clinical guidelines that are good examples of what is considered optimal care. Add to this all of the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions (e.g., hypertension and hyperlipidemia) has increased

Similarly, there are more informed patients who want to and should be actively involved in decision-making, and they bring more information with them to their visits. These patients are presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press. As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than it did ten years ago when E/M codes were last reviewed. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

Other compelling evidence for a change in work for this code is the additional documentation requirements added to physician work As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines.

There is also the greater role that genomics plays in the evaluation and potential management of patients. Ten years ago, the human genome had not been mapped. Now, it has. With the mapping and sequencing of the human genome, medical professionals from essentially all specialties have turned their attention to investigating the role genes play in health and disease, and genetic disease represents an important part of medical practice. Diagnosing a genetic disorder not only allows for disease-specific management options but also has implications for the affected individual's entire family. As such, a working understanding of the underlying concepts of genetic disease is necessary for today's practicing physician, and routine clinical practice requires integration of these fundamental concepts for use in accurate diagnosis and ensuring appropriate referrals for patients with genetic disease and their families. In addition, genomic information will become integral to the selection of treatment in a variety of disease conditions, adding a new dimension to disease management. All of this expands the knowledge base required for each E/M service since this information must be integrated with the traditional cognitive base.

Finally, there is evidence that the intensity of E/M services has increased over time. Support for the increased intensity of E/M services, particularly office visits, may be found in the results of the National Ambulatory Medical Care Survey. Data from this survey published by the Centers for Disease Control and Prevention in 2003 reflect increasing complexity and intensity of physician work in office practice from 1992-2002. Patients were older, had more complex diagnoses, more discussion of treatment and more mention of drugs used in treatment in 2002 than was the case in 1992 This is reinforced by the fact that close to half of the survey respondents cited patients as more complex as a reason the work of this service has changed over the last five years.

Because of this compelling evidence and survey respondents' indication that the current work has changed and is undervalued, we are recommending an increase in the work RVU for this code from 2.58 to 3.00, the median of our urvey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions. No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 98% No 2%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 98% less complex (less work) 0% no change 2%
C. The usual site-of-service has changed:
   from outpatient to inpatient 4% from inpatient to outpatient 68% no change 28%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time			
Clinical Staff #1	Staff Type	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time			
Clinical Staff #1	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code 99245 | Global Period: XXX | **Recommended Work Relative Value** Specialty Society RVU· **4.00** RUC RVU· **3.77**

CPT Descriptor Office 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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey A 63-year old male is seen for office consultation for a 20 pound weight loss, dysphagia and abdominal pain He has a history of coronary artery disease, osteoarthritis, chronic bronchitis, hypertension, gastroesophageal reflux disease, and hyperlipidemia and Type 2 diabetes mellitus. He is on multiple medications.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work
- Review referral records
- Review the medical history form completed by the patient and vital signs obtained by clinical staff
  Communicate with other health professionals

Description of Intra-Service Work:
- Obtain a comprehensive history
- Perform a comprehensive examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (high medical decision making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Write prescription(s), order and arrange diagnostic testing or referral as necessary

Description of Post-Service Work:
- Complete the medical record documentation
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit
- Receive and respond to any interval testing results or correspondence
- Revise treatment plan(s) and communicate with patient, as necessary
- Provide ongoing consultation to referring healthcare professional

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s)·	James Anthony, M.D. (AAN)

Specialty(s):	American Academy of Neurology, American Association of Clinical Endocrinologists, American College of Physicians, American Osteopathic Association, American College of Rheumatology, American Society of Clinical Oncology, and American Society of Hematology

CPT Code: 99245

Sample Size:	4784	**Resp n:** 94	**Response:** 1.96 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.40	3.77	**4.00**	4.55	400 00
Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	20.00	50.00	**60.00**	77.50	120.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**20.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19), 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care for the evaluation and management of a patient, including admission and discharge on the same date 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) requiring admission are of high severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 1 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

MPC CPT Code 2	Global	Work RVU
93508	XXX	4 09

CPT Descriptor 2 Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 21.2 %

TIME ESTIMATES (Median)	CPT Code: 99245	Key Reference CPT Code: 99236
Median Pre-Service Time	15.00	
Median Intra-Service Time	60.00	110.00
Median Immediate Post-service Time	20.00	
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**95.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.80	4.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	5.00	4.60
Urgency of medical decision making	4.90	4.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.60	4.40
Physical effort required	4.10	4.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4 80	4.60
Outcome depends on the skill and judgment of physician	4.90	4.40
Estimated risk of malpractice suit with poor outcome	4.50	4.10

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	4.30	4.20
Intra-Service intensity/complexity	4.90	4.80
Post-Service intensity/complexity	4.80	4.60

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Almost 97% of respondents indicated that they believe the work associated with this code has changed in the last five ears. Eighty-two percent of respondents stated the vignette is typical. Respondents rated the complexity/intensity measures higher for the survey code than for the reference code in every category.

We also think there is compelling evidence outside the survey for an increase in the work RVUs assigned to this code. For instance, there is a greater expectation that physicians will be proactive in disease prevention and diagnosing and

treating illness Physicians must be more opportunistic in addressing prevention. This need to be opportunistic is reinforced by the growing emphasis on ambulatory quality measures and pay-for-performance programs that focus on such measures

At the same time, there has been an increase in the complexity of data to be evaluated and care to be managed at such follow-up visits Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intraservice intensity of E/M services and increases the pre- and post-service time involved. There is also more polypharmacy and an explosion in the number of clinical guidelines that are good examples of what is considered optimal care. Add to this all of the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions (e.g., hypertension and hyperlipidemia) has increased.

Similarly, there are more informed patients who want to and should be actively involved in decision-making, and they bring more information with them to their visits. These patients are presenting to the office with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press. As a result, counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than it did ten years ago when E/M codes were last reviewed. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

Other compelling evidence for a change in work for this code is the additional documentation requirements added to physician work As noted in our comment letter to CMS, the implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines.

There is also the greater role that genomics plays in the evaluation and potential management of patients. Ten years ago, the human genome had not been mapped. Now, it has. With the mapping and sequencing of the human genome, medical professionals from essentially all specialties have turned their attention to investigating the role genes play in health and disease, and genetic disease represents an important part of medical practice. Diagnosing a genetic disorder not only allows for disease-specific management options but also has implications for the affected individual's entire family. As such, a working understanding of the underlying concepts of genetic disease is necessary for today's practicing physician, and routine clinical practice requires integration of these fundamental concepts for use in accurate diagnosis and ensuring appropriate referrals for patients with genetic disease and their families. In addition, genomic information will become integral to the selection of treatment in a variety of disease conditions, adding a new dimension to disease management. All of this expands the knowledge base required for each E/M service since this information must be integrated with the traditional cognitive base.

Finally, there is evidence that the intensity of E/M services has increased over time. Support for the increased intensity of E/M services, particularly office visits, may be found in the results of the National Ambulatory Medical Care Survey. Data from this survey published by the Centers for Disease Control and Prevention in 2003 reflect increasing complexity and intensity of physician work in office practice from 1992-2002. Patients were older, had more complex diagnoses, more discussion of treatment and more mention of drugs used in treatment in 2002 than was the case in 1992. This is reinforced by the fact that close to half of the survey respondents cited patients as more complex as a reason the work of this service has changed over the last five years.

Because of this compelling evidence and survey respondents' indication that the current work has changed and is undervalued, we are recommending an increase in the work RVU for this code from 3.42 to 4.00, the median of our survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%)

Has the work of performing this service changed in the past 5 years? Yes 96% No 3%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 0% I do not agree 100%
B. Patients requiring this service are now:
   more complex (more work) 94% less complex (less work) 1% no change 5%
C The usual site-of-service has changed:
   from outpatient to inpatient 3% from inpatient to outpatient 66% no change 31%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time.			
Clinical Staff #1	Staff Type.	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type.	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code 99251 | Global Period: XXX | **Recommended Work Relative Value**
Specialty Society RVU: **1.15**
RUC RVU: **1.00**

CPT Descriptor Initial inpatient consultation for a new or established patient, which requires these 3 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 provider 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey. Initial inpatient consultation for a 45-year-old female admitted with unrelenting low back pain for 2 days. There is no significant past medical history and she is on no medications. Neurological exam is normal

Percentage of Survey Respondents who found Vignette to be Typical: 67%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family
- Obtain and review necessary past results or records not available on the unit

Description of Intra-Service Work
- Review medical records and data available on the unit
- Obtain a problem focused history
- Perform a problem focused physical exam
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (straightforward medical decision making)
- Discuss diagnosis and treatment options with the patient and/or family
- Communicate with other health care professionals
- Write/review admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family
- Provide ongoing consultation to referring healthcare professional

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s)	Larry Martinelli, M D (IDSA)
Specialty(s):	American Osteopathic Assoc., American Academy of Neurology, Infectious Disease Society of America, American College of Physicians, and American Society of Hematology
CPT Code:	99251

Sample Size: 600	Resp n: 45	Response: 7.50 %
Sample Type: Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.70	1 00	**1.15**	1.73	3.45
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	15.00	**20.00**	30.00	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	5.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30), 99231 (19), 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99341	XXX	1.01

CPT Descriptor Home visit for evaluation and of a new patient, which requires these key components: problem focused history, 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 family's needs.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99315	XXX	1.13

CPT Descriptor 1 Nursing facility discharge day management; 30 minutes or less

MPC CPT Code 2	Global	Work RVU
99431	XXX	1.17

CPT Descriptor 2 History and examination of the normal newborn infant, initiation of diagnostic and treatment programs and preparation of hospital records. (This code should also be used for birthing room deliveries.)

Other Reference CPT Code	Global	Work RVU
99347	XXX	0.76

CPT Descriptor 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; 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.

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 0 **% of respondents:** 0.0 %

TIME ESTIMATES (Median)	CPT Code: 99251	Key Reference CPT Code: 99341
Median Pre-Service Time	5.00	6.00
Median Intra-Service Time	20.00	20.00
Median Immediate Post-service Time	5.00	10.00
Median Critical Care Time	0 0	0 00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00

Median Total Time	30.00	36.00
Other time if appropriate		

'NTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.80	1.60
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.90	1.60
Urgency of medical decision making	1.85	1.80

Technical Skill/Physical Effort (Mean)

Technical skill required	1.87	2.40
Physical effort required	1.56	2.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.90	1.40
Outcome depends on the skill and judgment of physician	2.32	2.60
Estimated risk of malpractice suit with poor outcome	2 54	2.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	1.48	1.40
Intra-Service intensity/complexity	2.14	1.80
Post-Service intensity/complexity	1.64	1.40

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an 'WPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value 'ecommendations for the appropriate formula and format.*

68% of survey respondents indicated that the work associated with this code had changed in the past five years. The survey respodents' median recommended work RVU is 1.15; the 25th percentile is 1.00, which is substantially above the current work RVU of 0.66- indicating that many of the respondents who stated that the work had not changed in the past five years, in fact, believe the work RVU is currently undervalued.

67% of the respondents responded that the vignette was typical for the service.

Respondents' choice of a key reference service was diffuse because the high number of E/M service codes included in he Five-Year Review limited the number of E/M codes-the most logical choice for a direct comparison of work—available as reference codes.

Additional documentation requirements added to physician work

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits

The impact of increased documentation requirements on intraservice work and pre- and post-service time cannot be overestimated A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation requirements in the previous five years.2

An increase in the complexity of data to be evaluated and care to be managed.

Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intra-service intensity of E/M services and increases the pre- and post-service time involved. As noted below, there are more informed consumers who want to and should be actively involved in decision-making, and they bring more information with them to their visits.

There is also more polypharmacy For example, heart failure programs expect the concurrent management of 5-7 medications, and the JNC 7 hypertension recommendations3 support 2-4 medications for good control.

Further, there has been an explosion in the number of clinical guidelines that are examples of what is considered optimal care. Add to this the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions (e.g., diabetes) has increased.4,5

We also note that the benefits of the successful co-management of the concurrent conditions of hypertension, diabetes, lipid abnormalities, and obesity have been demonstrated in clinical trials. Patients successfully treated in all areas had a 53% lower risk for cardiovascular disease.6 The application of the proven benefits of currently available therapies requires both intense and effective direct patient contact and expanded pre- and post-visit attention. The value of such continuous effective care needs to be recognized by appropriately valuing E/M services.

The intensity of E/M services has increased over time.

Hospital length of stay has changed

Hospital length of stay has decreased in the last ten years. According to Medicare data, in 1990, the average length of stay in all short-stay hospitals was 9.0 days. In 2001, the corresponding length of stay was 6.0 days.15,16

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Some of this care is provided by hospitalists. The emergence of the hospitalist as a specialist in inpatient medicine is another change in medical care that has occurred in the last ten years. Hospitals, health systems and health maintenance organizations have used hospitalists as a means to reduce length of stays and more efficiently manage inpatient care.17 Their success in doing so is unclear 18 However the extent that the use of hospitalists has had on hospital length of stay nd medical practice, and the impact which this may have on the work associated with E/M services remains unmeasured.

The impact of shorter lengths of stay is compounded by and compounds other changes that we have described For instance, we believe that patients are more complex upon admission due to such factors as an increasing number of chronic illnesses and expanding polypharmacy. In turn, shorter lengths of stay likely means that patients are sicker and more complex on discharge, which potentially affects both hospital discharge services and the complexity of services in the outpatient setting. All of this has implications for the work of E/M services in the inpatient setting which must, therefore, be reviewed during the five-year review

The Information Explosion

Patients and families present to the hospital with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press.

There is a new paradigm of medical decision-making that has evolved over the last ten years. The doctor and patient are in a collaborative relationship, each with unique and important information components. Decisions are now "shared," which is to say that the hierarchy of physicians instructing patient has been replaced by a more equal doctor-patient discussion around diagnostic testing and treatment strategies.7,8

Additionally, ten years ago, the Internet and World Wide Web were a novelty accessed by few and used effectively by even fewer. The Internet and World Wide Web are now part of everyday life, accessed daily by millions of Americans. Ten years ago the National Library of Medicine's database was available as a pay as you go or subscripiton service. Today, the entire database is freely available to anyone with an Internet connection via PubMed. As with any technological advance, the growth of the Internet has both positive aspects (i.e., more information available more readily to more people) and negative aspects (i e., more misinformation available more readily to more people). Patients today routinely present to the hospital with information that they have gleaned from the Internet and with questions about the veracity and applicability of that information in their own circumstances.

As a result, the counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than ten years ago. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVU for this code from 0.66 to 1.15, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.

- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario

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Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 68% No 31%

A. This service represents new technology that has become more familiar (i.e., less work):
I agree 0% I do not agree 100%

B. Patients requiring this service are now:
more complex (more work) 96% less complex (less work) 3% no change 1%

C. The usual site-of-service has changed:
from outpatient to inpatient 7% from inpatient to outpatient 10% no change 83%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code 99252 | Global Period: XXX | **Recommended Work Relative Value** Specialty Society RVU: **1.81** RUC RVU: **1.50**

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these 3 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial inpatient consultation for a 76-year-old female admitted for evaluation and treatment of a painful and swollen shoulder and hand She has well controlled hypertension.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family
- Obtain and review necessary past results or records not available on the unit

Description of Intra-Service Work
- Review medical records and data available on the unit
- Obtain a expanded history
- Perform a expanded physical exam
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (straightforward medical decision making)
- Discuss diagnosis and treatment options with the patient and/or family
- Communicate with other health care professionals
- Write/review admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work.
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family
- Provide ongoing consultation to referring healthcare professional

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s)	Larry Martinelli, M D (IDSA)
Specialty(s):	American Osteopathic Assoc., American Academy of Neurology, Infectious Disease Society of America, American College of Physicians, and American Society of Hematology
CPT Code:	99252

Sample Size: 600	Resp n: 45	Response: 7.50 %
Sample Type: Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	1.50	**1.81**	2.80	20.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	20.00	**35.00**	40.00	60 00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	10.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19), 99238 (36); 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99235	XXX	3.41

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date 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) requiring admission are of moderate severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
70496	XXX	1.75

CPT Descriptor 1 Computed tomographic angiography, head, without contrast material(s), followed by contrast material(s) and further sections, including image post-processing

MPC CPT Code 2	Global	Work RVU
99386	XXX	1.88

CPT Descriptor 2 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, new patient, 40-64 years

Other Reference CPT Code	Global	Work RVU
99347	XXX	0.76

CPT Descriptor 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; 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.

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 4 **% of respondents:** 8.8 %

TIME ESTIMATES (Median)	CPT Code: 99252	Key Reference CPT Code: 99235
Median Pre-Service Time	5.00	10.00
Median Intra-Service Time	35.00	75.00
Median Immediate Post-service Time	10.00	15.00

Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**50.00**	**100.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.41	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.56	3.00
Urgency of medical decision making	2.51	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	2.51	3.00
Physical effort required	2.13	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.59	3.00
Outcome depends on the skill and judgment of physician	2.85	4.00
Estimated risk of malpractice suit with poor outcome	3.02	4.00

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	2.00	3.00
Intra-Service intensity/complexity	2.84	3.00
Post-Service intensity/complexity	2.32	3.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

70% of survey respondents indicated that the work associated with this code had changed in the past five years. 62% of he respondents felt that the complexity of this code had increased in the past five years. None felt that it had stayed the same or decreased The survey respodents' median recommended work RVU is 1.81; the 25th percentile is 1.50, which is substantially above the current work RVU of 1.32- indicating that many of the respondents who stated that the work had not changed in the past five years, in fact, believe the work RVU is currently undervalued.

80% if the respondents responded that the vignette was typical for the service

8.8% of respondents chose the key reference code. The respondents choice of a key reference service was diffuse because the high number of E/M service codes included in the Five-Year Review limited the number of E/M codes ~~the~~ most logical choice for a direct comparison of work ~~a~~available as reference codes.

Although the surveyed code (99252) is only 53% of the key reference code in recommended work RVU, this is consistent with the total time of the surveyed code being 55% of the key reference code. The measures of intensity for the survey code are also proportionately lower than for the key reference code.

[Do we really want to make this last point??? It may make the IWPUT look bad for our code.]

Additional documentation requirements added to physician work

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The impact of increased documentation requirements on intraservice work and pre- and post-service time cannot be overestimated. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation requirements in the previous five years.2

An increase in the complexity of data to be evaluated and care to be managed.

Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intra-service intensity of E/M services and increases the pre- and post-service time involved. As noted below, there are more informed consumers who want to and should be actively involved in decision-making, and they bring more information with them to their visits.

There is also more polypharmacy For example, heart failure programs expect the concurrent management of 5-7 medications, and the JNC 7 hypertension recommendations3 support 2-4 medications for good control.

Further, there has been an explosion in the number of clinical guidelines that are examples of what is considered optimal care. Add to this the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions (e.g , diabetes) has increased.4,5

We also note that the benefits of the successful co-management of the concurrent conditions of hypertension, diabetes, lipid abnormalities, and obesity have been demonstrated in clinical trials. Patients successfully treated in all areas had a

53% lower risk for cardiovascular disease.6 The application of the proven benefits of currently available therapies requires both intense and effective direct patient contact and expanded pre- and post-visit attention. The value of such continuous effective care needs to be recognized by appropriately valuing E/M services.

The intensity of E/M services has increased over time.

Hospital length of stay has changed

Hospital length of stay has decreased in the last ten years. According to Medicare data, in 1990, the average length of stay in all short-stay hospitals was 9.0 days In 2001, the corresponding length of stay was 6.0 days.15,16

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Some of this care is provided by hospitalists. The emergence of the hospitalist as a specialist in inpatient medicine is another change in medical care that has occurred in the last ten years. Hospitals, health systems and health maintenance organizations have used hospitalists as a means to reduce length of stays and more efficiently manage inpatient care.17 Their success in doing so is unclear 18 However the extent that the use of hospitalists has had on hospital length of stay and medical practice, and the impact which this may have on the work associated with E/M services remains unmeasured

The impact of shorter lengths of stay is compounded by and compounds other changes that we have described. For instance, we believe that patients are more complex upon admission due to such factors as an increasing number of chronic illnesses and expanding polypharmacy. In turn, shorter lengths of stay likely means that patients are sicker and more complex on discharge, which potentially affects both hospital discharge services and the complexity of services in the outpatient setting. All of this has implications for the work of E/M services in the inpatient setting which must, therefore, be reviewed during the five-year review.

The Information Explosion

Patients and families present to the hospital with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press.

There is a new paradigm of medical decision-making that has evolved over the last ten years. The doctor and patient are in a collaborative relationship, each with unique and important information components. Decisions are now "shared," which is to say that the hierarchy of physicians instructing patient has been replaced by a more equal doctor-patient discussion around diagnostic testing and treatment strategies.7,8

Additionally, ten years ago, the Internet and World Wide Web were a novelty accessed by few and used effectively by even fewer. The Internet and World Wide Web are now part of everyday life, accessed daily by millions of Americans. Ten years ago the National Library of Medicine's database was available as a pay as you go or subscripiton service. Today, the entire database is freely available to anyone with an Internet connection via PubMed. As with any technological advance, the growth of the Internet has both positive aspects (i.e., more information available more readily to more people) and negative aspects (i.e., more misinformation available more readily to more people). Patients today routinely present to the hospital with information that they have gleaned from the Internet and with questions about the veracity and applicability of that information in their own circumstances.

As a result, the counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than ten years ago. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVU for this code from 1.32 to 1.81, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

.. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions. No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%).

Has the work of performing this service changed in the past 5 years? Yes 70% No 29%

A. This service represents new technology that has become more familiar (i.e., less work):
I agree 0% I do not agree 100%
B. Patients requiring this service are now:
more complex (more work) 96% less complex (less work) 0% no change 4%
C. The usual site-of-service has changed:
from outpatient to inpatient 6% from inpatient to outpatient 13% no change 81%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time.			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time			
Clinical Staff #1	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99253 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **2.50**
RUC RVU: **2.27**

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these 3 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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey. Initial inpatient consultation for a 75-year old white female status post right hip fracture with a history of hypertension and well-controlled Type 2 diabetes mellitus. Consultation is requested for surgical clearance.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family
- Obtain and review necessary past results or records not available on the unit

Description of Intra-Service Work.
- Review medical records and data available on the unit
- Obtain a detailed history
- Perform a detailed physical exam
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (low complexity medical decision making)
- Discuss diagnosis and treatment options with the patient and/or family
- Communicate with other health care professionals
- Write/review admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family
- Provide ongoing consultation to referring healthcare professional

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s)	Larry Martinelli, M D. (IDSA)
Specialty(s):	American Osteopathic Assoc., American Academy of Neurology, Infectious Disease Society of America, American College of Physicians, and American Society of Hematology
CPT Code:	99253

Sample Size: 600	Resp n: 50	Response: 8.33 %
Sample Type: Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.18	2.00	**2.50**	3.01	4.75
Pre-Service Evaluation Time:			**10.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	10.00	30.00	**40.00**	53.80	60.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	15.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99234	XXX	2.56

CPT Descriptor Observation or inpatient hospital care, for the evaluation and mangement of a patient including admission and discharge on the same date which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and a medical decision making that is straighforward 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) requiring admission are of low severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
93312	XXX	2.20

CPT Descriptor 1 Echocardiography, transesophageal, real time with image documentation (2D) (with or without recording); including probe placement, image acquisition, interpretation and report

MPC CPT Code 2	Global	Work RVU
90801	XXX	2 80

CPT Descriptor 2 Psychiatric diagnostic interview examination

Other Reference CPT Code	Global	Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 9 **% of respondents:** 18.0 %

TIME ESTIMATES (Median)	CPT Code: 99253	Key Reference CPT Code: 99234
Median Pre-Service Time	10.00	10.00
Median Intra-Service Time	40.00	60.00
Median Immediate Post-service Time	15.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**65.00**	**85.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.22	3.11
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.33	3.11
Urgency of medical decision making	3.22	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.30	3 11
Physical effort required	2.74	2.89

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3 27	3.22
Outcome depends on the skill and judgment of physician	3.49	3.56
Estimated risk of malpractice suit with poor outcome	3.49	3.67

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.69	2.67
Intra-Service intensity/complexity	3.40	3.17
Post-Service intensity/complexity	2.96	2.83

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

78% of survey respondents indicated that the work associated with this code had changed in the past five years. 72% of ıe respondents felt that the complexity of this code had increased in the past five years. None felt that it had stayed the same or decreased. The survey respodents' median recommended work RVU is 2.50; the 25th percentile is 2.00, which is substantially above the current work RVU of 1.82- indicating that many of the respondents who stated that the work had not changed in the past five years, ın fact, believe the work RVU is currently undervalued.

73% if the respondents responded that the vignette was typical for the service

18% of respondents chose the key reference code. The respondents choice of a key reference service was diffuse because the high number of E/M service codes included in the Five-Year Review limited the number of E/M codes-the most ogical choice for a direct comparison of work-available as reference codes.

Although the surveyed code has a shorter total time than the key reference code, respondents felt that the survyeed code is more complex on two of the three measures of mental effort and judgement, required more technical skill, and has a higher intensity/complexity of work in all three time components than the key reference code

Additional documentation requirements added to physician work

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The impact of increased documentation requirements on intraservice work and pre- and post-service time cannot be overestimated. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation requirements in the previous five years.2

An increase in the complexity of data to be evaluated and care to be managed.

Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intra-service intensity of E/M services and increases the pre- and post-service time involved. As noted below, there are more informed consumers who want to and should be actively involved in decision-making, and they bring more information with them to their visits.

There is also more polypharmacy. For example, heart failure programs expect the concurrent management of 5-7 medications, and the JNC 7 hypertension recommendations3 support 2-4 medications for good control.

Further, there has been an explosion in the number of clinical guidelines that are examples of what is considered optimal care. Add to this the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions (e.g., diabetes) has increased.4,5

We also note that the benefits of the successful co-management of the concurrent conditions of hypertension, diabetes, lipid abnormalities, and obesity have been demonstrated in clinical trials. Patients successfully treated in all areas had a 53% lower risk for cardiovascular disease.6 The application of the proven benefits of currently available therapies requires both intense and effective direct patient contact and expanded pre- and post-visit attention. The value of such continuous effective care needs to be recognized by appropriately valuing E/M services.

The intensity of E/M services has increased over time.

Hospital length of stay has changed

Hospital length of stay has decreased in the last ten years. According to Medicare data, in 1990, the average length of stay in all short-stay hospitals was 9.0 days. In 2001, the corresponding length of stay was 6.0 days.15,16

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Some of this care is provided by hospitalists. The emergence of the hospitalist as a specialist in inpatient medicine is another change in medical care that has occurred in the last ten years. Hospitals, health systems and health maintenance organizations have used hospitalists as a means to reduce length of stays and more efficiently manage inpatient care.17 Their success in doing so is unclear.18 However the extent that the use of hospitalists has had on hospital length of stay and medical practice, and the impact which this may have on the work associated with E/M services remains unmeasured.

The impact of shorter lengths of stay is compounded by and compounds other changes that we have described. For instance, we believe that patients are more complex upon admission due to such factors as an increasing number of chronic illnesses and expanding polypharmacy. In turn, shorter lengths of stay likely means that patients are sicker and more complex on discharge, which potentially affects both hospital discharge services and the complexity of services in the outpatient setting. All of this has implications for the work of E/M services in the inpatient setting which must, therefore, be reviewed during the five-year review.

The Information Explosion

Patients and families present to the hospital with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press.

There is a new paradigm of medical decision-making that has evolved over the last ten years. The doctor and patient are in a collaborative relationship, each with unique and important information components. Decisions are now "shared," which is to say that the hierarchy of physicians instructing patient has been replaced by a more equal doctor-patient discussion around diagnostic testing and treatment strategies.7,8

Additionally, ten years ago, the Internet and World Wide Web were a novelty accessed by few and used effectively by even fewer. The Internet and World Wide Web are now part of everyday life, accessed daily by millions of Americans. Ten years ago the National Library of Medicine's database was available as a pay as you go or subscripiton service. Today, the entire database is freely available to anyone with an Internet connection via PubMed. As with any technological advance, the growth of the Internet has both positive aspects (i.e., more information available more readily to more people) and negative aspects (i.e., more misinformation available more readily to more people). Patients today routinely present to the hospital with information that they have gleaned from the Internet and with questions about the veracity and applicability of that information in their own circumstances.

As a result, the counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than ten years ago. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVU for this code from 1.82 to 2.50, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 78% No 21%

A. This service represents new technology that has become more familiar (i.e., less work):
I agree 0% I do not agree 100%
B. Patients requiring this service are now:
more complex (more work) 97% less complex (less work) 0% no change 3%
C. The usual site-of-service has changed:
from outpatient to inpatient 13% from inpatient to outpatient 16% no change 71%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99254 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **3.50**
RUC RVU: **3.29**

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these 3 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey Initial inpatient consultation for a 75-year-old female admitted with cellulitis around a right great toe ulcer. She has a history of Type 2 diabetes mellitus, ischemic cardiomyopathy, atherosclerotic peripheral vascular disease, hypertension and chronic renal insufficiency. She is a widow living in a nursing home. She has developed a fever and hot, swollen painful left knee.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work.
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family
- Obtain and review necessary past results or records not available on the unit

Description of Intra-Service Work:
- Review medical records and data available on the unit
- Obtain a comprehensive history
- Perform a comprehensive physical exam
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (moderate complexity medical decision making)
- Discuss diagnosis and treatment options with the patient and/or family
- Communicate with other health care professionals
- Write/review admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work:
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family
- Provide ongoing consultation to referring healthcare professional

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Larry Martinelli, M D (IDSA)
Specialty(s):	American Osteopathic Assoc., American Academy of Neurology, Infectious Disease Society of America, American College of Physicians, and American Society of Hematology

CPT Code:	99254		
Sample Size:	600	Resp n: 50	Response: 8.33 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.26	3.00	**3.50**	3.80	5.00
Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	15.00	35.00	**50.00**	71.30	95.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	20.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99235	XXX	3.41

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date 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) requiring admission are of moderate severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
99040	XXX	2.93

CPT Descriptor 1 Newborn resuscitation: provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

MPC CPT Code 2	Global	Work RVU
95810	XXX	3 52

CPT Descriptor 2 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU
95978	XXX	3.52

CPT Descriptor Electronic analysis of implanted neurotransmitter pulse generator system (eg. rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements) complex deep brain neurotranstimulator pulse generator/transimitter, with intitial or subsequent programming, first hour

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 14 **% of respondents:** 28.0 %

TIME ESTIMATES (Median)

	CPT Code: 99254	Key Reference CPT Code: 99235
Median Pre-Service Time	15.00	10.00
Median Intra-Service Time	50.00	75.00
Median Immediate Post-service Time	20.00	15.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00

Median Office Visit Time	0.0	0.00
Median Total Time	**85.00**	**100.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4 18	4.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.31	4.38
Urgency of medical decision making	4.23	4.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.07	4 15
Physical effort required	3.40	3.23

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.27	4 15
Outcome depends on the skill and judgment of physician	4.42	4.38
Estimated risk of malpractice suit with poor outcome	4.31	4.15

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.50	3.69
Intra-Service intensity/complexity	4.31	4.00
Post-Service intensity/complexity	3.92	3.92

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an MPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

82% of survey respondents indicated that the work associated with this code had changed in the past five years. 83% of the respondents felt that the complexity of this code had increased in the past five years. None felt that it had stayed the

same or decreased. The survey respodents' median recommended work RVU is 3.50; the 25th percentile is 3.00, which is substantially above the current work RVU of 2.64.

83% if the respondents responded that the vignette was typical for the service

28% of respondents chose the key reference code. The respondents choice of a key reference service was diffuse because the high number of E/M service codes included in the Five-Year Review limited the number of E/M codes ~~the~~ most logical choice for a direct comparison of work ~~a~~available as reference codes.

Although the surveyed code has a shorter total time than the key reference code, respondents felt that the survyeed code is more complex on two of the three measures of mental effort and judgement, required more physical effort, had a higer psychological stress in all three areas measured, and has the same or higher intensity/complexity of work in two of the three time components than the key reference code.

Additional documentation requirements added to physician work

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services. These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The impact of increased documentation requirements on intraservice work and pre- and post-service time cannot be overestimated. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation requirements in the previous five years.2

An increase in the complexity of data to be evaluated and care to be managed.

Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intra-service intensity of E/M services and increases the pre- and post-service time involved. As noted below, there are more informed consumers who want to and should be actively involved in decision-making, and they bring more information with them to their visits.

There is also more polypharmacy. For example, heart failure programs expect the concurrent management of 5-7 medications, and the JNC 7 hypertension recommendations3 support 2-4 medications for good control.

Further, there has been an explosion in the number of clinical guidelines that are examples of what is considered optimal care. Add to this the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions (e.g., diabetes) has increased.4,5

We also note that the benefits of the successful co-management of the concurrent conditions of hypertension, diabetes, lipid abnormalities, and obesity have been demonstrated in clinical trials. Patients successfully treated in all areas had a 53% lower risk for cardiovascular disease.6 The application of the proven benefits of currently available therapies requires both intense and effective direct patient contact and expanded pre- and post-visit attention. The value of such continuous effective care needs to be recognized by appropriately valuing E/M services.

The intensity of E/M services has increased over time.

Hospital length of stay has changed

Hospital length of stay has decreased in the last ten years. According to Medicare data, in 1990, the average length of stay in all short-stay hospitals was 9.0 days. In 2001, the corresponding length of stay was 6.0 days.15,16

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Some of this care is provided by hospitalists. The emergence of the hospitalist as a specialist in inpatient medicine is another change in medical care that has occurred in the last ten years. Hospitals, health systems and health maintenance organizations have used hospitalists as a means to reduce length of stays and more efficiently manage inpatient care.17 Their success in doing so is unclear 18 However the extent that the use of hospitalists has had on hospital length of stay and medical practice, and the impact which this may have on the work associated with E/M services remains unmeasured.

The impact of shorter lengths of stay is compounded by and compounds other changes that we have described. For instance, we believe that patients are more complex upon admission due to such factors as an increasing number of chronic illnesses and expanding polypharmacy. In turn, shorter lengths of stay likely means that patients are sicker and more complex on discharge, which potentially affects both hospital discharge services and the complexity of services in the outpatient setting. All of this has implications for the work of E/M services in the inpatient setting which must, therefore, be reviewed during the five-year review.

The Information Explosion

Patients and families present to the hospital with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press.

There is a new paradigm of medical decision-making that has evolved over the last ten years. The doctor and patient are in a collaborative relationship, each with unique and important information components. Decisions are now "shared," which is to say that the hierarchy of physicians instructing patient has been replaced by a more equal doctor-patient discussion around diagnostic testing and treatment strategies.7,8

Additionally, ten years ago, the Internet and World Wide Web were a novelty accessed by few and used effectively by even fewer. The Internet and World Wide Web are now part of everyday life, accessed daily by millions of Americans. Ten years ago the National Library of Medicine's database was available as a pay as you go or subscripiton service. Today, the entire database is freely available to anyone with an Internet connection via PubMed. As with any technological advance, the growth of the Internet has both positive aspects (i.e., more information available more readily to more people) and negative aspects (i.e , more misinformation available more readily to more people). Patients today routinely present to the hospital with information that they have gleaned from the Internet and with questions about the veracity and applicability of that information in their own circumstances.

As a result, the counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than ten years ago. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVU for this code from 2.64 to 3.50, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 83% No 16%

A. This service represents new technology that has become more familiar (i.e., less work):
I agree 0% I do not agree 100%
B. Patients requiring this service are now:
more complex (more work) 100% less complex (less work) 0% no change 0%
C. The usual site-of-service has changed:
from outpatient to inpatient 12% from inpatient to outpatient 10% no change 78%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from bove to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time.			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99255 Global Period: XXX Specialty Society RVU: **4.50**

RUC RVU: **4.00**

CPT Descriptor: Initial inpatient consultation for a new or established patient, which requires these 3 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

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial inpatient consultation for a 75-year-old female admitted with cellulitis around a right great toe ulcer. She has a history of Type 2 diabetes mellitus, ischemic cardiomyopathy, atherosclerotic peripheral vascular disease, hypertension and chronic renal insufficiency. She is a widow living in a nursing home. She is delirious and febrile.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical? 0%

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work:
- Review data not available on the unit (e.g. diagnostic and imaging studies)
- Communicate with other professionals and with patient or patient's family
- Obtain and review necessary past results or records not available on the unit

Description of Intra-Service Work:
- Review medical records and data available on the unit
- Obtain a comprehensive history
- Perform a comprehensive physical exam
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (high complexity medical decision making)
- Discuss diagnosis and treatment options with the patient and/or family
- Communicate with other health care professionals
- Write/review admission orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic intervention(s)
- Complete medical record documentation

Description of Post-Service Work
- Address interval data obtained and changes in condition reported
- Communicate results and further care plans to other health care professionals and to the patient and/or family
- Provide ongoing consultation to referring healthcare professional

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SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2005
Presenter(s):	Larry Martinelli, M D. (IDSA)
Specialty(s):	American Osteopathic Assoc., American Academy of Neurology, Infectious Disease Society of America, American College of Physicians, and American Society of Hematology

CPT Code:	99255		
Sample Size:	600	Resp n: 50	Response: 8.33 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.33	4.00	**4.50**	5.00	7.00
Pre-Service Evaluation Time:			**20.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	15.00	50.00	**60.00**	75.00	120.00

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	25.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36), 99215 (59), 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care, for the evaluation and mangement of a patient including admission and discharge on the same date which requires these three 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) requiring admission are of high severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 1 Polysomnography, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

MPC CPT Code 2	Global	Work RVU
36245	XXX	4.67

CPT Descriptor 2 Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family

Other Reference CPT Code	Global	Work RVU
48552	XXX	4.30

CPT Descriptor Back bench reconstruction of cadaver donor pancreas allograph prior to transplantation, venous anastomosis, each

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 21 **% of respondents:** 42.0 %

TIME ESTIMATES (Median)	CPT Code: 99255	Key Reference CPT Code: 99236
Median Pre-Service Time	20.00	0.00
Median Intra-Service Time	60.00	110.00
Median Immediate Post-service Time	25.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**105.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.78	4.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4 91	4.95
Urgency of medical decision making	4.78	4.80

Technical Skill/Physical Effort (Mean)

Technical skill required	4.51	4.52
Physical effort required	3.74	3.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.84	4.67
Outcome depends on the skill and judgment of physician	4.76	4.67
Estimated risk of malpractice suit with poor outcome	4 60	4 48

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	4.10	4.38
Intra-Service intensity/complexity	4.88	4.81
Post-Service intensity/complexity	4.54	4.76

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

98% of survey respondents indicated that the work associated with this code had changed in the past five years. 82% of ie respondents felt that the complexity of this code had increased in the past five years. None felt that it had stayed the same or decreased. The survey respodents' median recommended work RVU is 4.50; the 25th percentile is 4.00, which is substantially above the current work RVU of 3.64.

82% if the respondents felt that the vignette was typical for the service

42% of respondents chose the key reference code. The respondents choice of a key reference service was diffuse because the high number of E/M service codes included in the Five-Year Review limited the number of E/M codes-the most logical choice for a direct comparison of work-available as reference codes.

The surveyed code has a shorter total time than the key reference code selected. Respondents felt that the surveyed code had a higher psychological stress than the selected reference code across all three measures. The surveyed code was also felt to have a higher intra-service intensity/complexity of service than the reference code.

Additional documentation requirements added to physician work

The implementation of the 1995 and 1997 Medicare E/M documentation guidelines has increased documentation demands related to stand-alone E/M services These guidelines did not exist the last time the E/M codes were reviewed. This adds to the physician work of E/M services relative to other services, which are not subject to the documentation guidelines. Even global surgical services, which include an E/M component, are unaffected by the advent of the documentation guidelines, since E/M services in the global period are not separately reported.

Medicare is not the only entity requiring increased documentation. The Joint Commission on the Accreditation of Healthcare Organizations has also increased its documentation requirements as it relates to hospital visits.

The impact of increased documentation requirements on intraservice work and pre- and post-service time cannot be overestimated. A survey of clinical oncologists, backed up by activity logs and site visits, revealed that more than 97% of survey respondents reported an increase in documentation (averaging 1.4 hours per day) and 77% reported an increase in work hours because of documentation requirements in the previous five years.2

An increase in the complexity of data to be evaluated and care to be managed.

Evaluation and management of patients involves integrating much more information than it did ten years ago, which increases the intra-service intensity of E/M services and increases the pre- and post-service time involved. As noted below, there are more informed consumers who want to and should be actively involved in decision-making, and they bring more information with them to their visits.

There is also more polypharmacy For example, heart failure programs expect the concurrent management of 5-7 medications, and the JNC 7 hypertension recommendations3 support 2-4 medications for good control.

Further, there has been an explosion in the number of clinical guidelines that are examples of what is considered optimal care Add to this the new diagnostic and screening tests that have come into existence over the past ten years, with their corresponding results to be considered and follow-up on as required, and it is no wonder that the complexity of care of even the most common conditions (e.g., diabetes) has increased.4,5

We also note that the benefits of the successful co-management of the concurrent conditions of hypertension, diabetes, lipid abnormalities, and obesity have been demonstrated in clinical trials. Patients successfully treated in all areas had a 53% lower risk for cardiovascular disease.6 The application of the proven benefits of currently available therapies requires both intense and effective direct patient contact and expanded pre- and post-visit attention. The value of such continuous effective care needs to be recognized by appropriately valuing E/M services.

The intensity of E/M services has increased over time.

Hospital length of stay has changed.

Hospital length of stay has decreased in the last ten years. According to Medicare data, in 1990, the average length of stay in all short-stay hospitals was 9 0 days In 2001, the corresponding length of stay was 6.0 days.15,16

Shortened length of stay has been accomplished with the combined efforts of hospitals, insurance carriers, and home care service companies and the effective and rapid use of new diagnostic tests and powerful new therapies. The orchestration of all this care, however, requires the intense efforts of physicians in the inpatient setting.

Some of this care is provided by hospitalists. The emergence of the hospitalist as a specialist in inpatient medicine is another change in medical care that has occurred in the last ten years. Hospitals, health systems and health maintenance organizations have used hospitalists as a means to reduce length of stays and more efficiently manage inpatient care.17 Their success in doing so is unclear.18 However the extent that the use of hospitalists has had on hospital length of stay and medical practice, and the impact which this may have on the work associated with E/M services remains unmeasured.

The impact of shorter lengths of stay is compounded by and compounds other changes that we have described. For instance, we believe that patients are more complex upon admission due to such factors as an increasing number of chronic illnesses and expanding polypharmacy. In turn, shorter lengths of stay likely means that patients are sicker and more complex on discharge, which potentially affects both hospital discharge services and the complexity of services in the outpatient setting. All of this has implications for the work of E/M services in the inpatient setting which must, therefore, be reviewed during the five-year review.

The Information Explosion

Patients and families present to the hospital with a greater expectation of participating in medical decision-making and with more information from the Internet and lay press.

There is a new paradigm of medical decision-making that has evolved over the last ten years. The doctor and patient are in a collaborative relationship, each with unique and important information components. Decisions are now "shared," which is to say that the hierarchy of physicians instructing patient has been replaced by a more equal doctor-patient discussion around diagnostic testing and treatment strategies.7,8

Additionally, ten years ago, the Internet and World Wide Web were a novelty accessed by few and used effectively by even fewer. The Internet and World Wide Web are now part of everyday life, accessed daily by millions of Americans. Ten years ago the National Library of Medicine's database was available as a pay as you go or subscripiton service. Today, the entire database is freely available to anyone with an Internet connection via PubMed. As with any technological advance, the growth of the Internet has both positive aspects (i.e., more information available more readily to more people) and negative aspects (i.e., more misinformation available more readily to more people). Patients today routinely present to the hospital with information that they have gleaned from the Internet and with questions about the veracity and applicability of that information in their own circumstances.

As a result, the counseling and coordination of care that physicians do within the context of E/M services requires more time and better preparation than ten years ago. Physicians must be more mindful of the popular impressions and expectations, both good and bad, created by the mass media and developed on the Internet.

We believe that the survey data and the additional rationale provide compelling evidence that justifies our recommended increase in the work RVU for this code from 3.64 to 4.50, the median survey response.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 98% No 2%

A. This service represents new technology that has become more familiar (i e , less work):
I agree 0% I do not agree 100%
B. Patients requiring this service are now:
more complex (more work) 95% less complex (less work) 0% no change 5%
C. The usual site-of-service has changed
from outpatient to inpatient 11% from inpatient to outpatient 9% no change 80%

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: NA

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99281 Global Period: XXX Specialty Society RVU: **0.50**

RUC RVU: **0.45**

CPT Descriptor: Emergency department visit for the evaluation and management of a 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 patients and/or family's needs. Usually, the presenting problem(s) are self limited or minor.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents to the emergency department for suture removal status post repair of a forearm laceration by a different provider in another different location. There are no complaints and the wound appears well-healed.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: According to the RUC E/M survey instrument for emergency medicine services, the service period is treated as a whole and includes the work from the time you initially review the patient's records until you complete their chart. In other words, pre and post service periods do not apply.

According to CPT "Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for the physicians to provide accurate estimates of the time spent face-to-face with a patient."

Description of Intra-Service Work:
-preparing to see the patient
- review records
- communicating with other professionals
-evaluation of the patient including:
- a problem focused history
- a problem focused exam, and
- straightforward decision making
-documentation of the medical record
-coordination of care of this patient after discharge from the emergency department.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005
Presenter(s):	Dennis Beck, MD, FACEP
Specialty(s):	Emergency Medicine
CPT Code:	99281

CPT Code:

Sample Size: 320	Resp n: 101	Response: 31.56 %
Sample Type: Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.17	0.39	**0.50**	0.80	1.01
Pre-Service Evaluation Time:			**2.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:			**7.00**		

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	4.00	
Critical Care time/visit(s):	0.0	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	0.0	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	0.0	99238x **0.00** 99239x **0.00**
Office time/visit(s):	0.0	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
90862	XXX	0.95

CPT Descriptor Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU
93790	XXX	0.38

CPT Descriptor Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; physician review with interpretation and report

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 18 **% of respondents:** 17.8 %

TIME ESTIMATES (Median)	**CPT Code: 99281**	**Key Reference CPT Code: 90862**
Median Pre-Service Time	2.00	
Median Intra-Service Time	7.00	
Median Immediate Post-service Time	4.00	
Median Critical Care Time	0.0	
Median Other Hospital Visit Time	0.0	
Median Discharge Day Management Time	0.0	
Median Office Visit Time	0.0	
Median Total Time	**13.00**	
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	1.37	1 18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.21	1.12
Urgency of medical decision making	1.38	1 12

Technical Skill/Physical Effort (Mean)

Technical skill required	1.33	1.00
Physical effort required	1.18	1.06

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.27	1.12
Outcome depends on the skill and judgment of physician	1.31	1.00
Estimated risk of malpractice suit with poor outcome	1.72	1.18

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The majority of survey respondents indicated that the work associated with 99281 had not changed over the past ten ears, however they recommended a RVW higher than the curent value of 0.33. We interpret this to mean that although they indicated that the work had not changed, they also believed the code was currently undervalued. It should be noted that this code has not previously been surveyed by the RUC.

ACEP recommends the survey median of 0.50 RVW for code 99281.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example .05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 11% No 88%

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) 72% less complex (less work) 9% no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 1% no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 99281

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½,or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99282 Global Period: XXX Specialty Society RVU **1.00**

RUC RVU: **0.88**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, which requires these three key components: 1) an expanded problem focused history; 2) an expanded problem focused 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 patients and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient presents to the emergency department complaining of a pruritic rash on both legs of one day's duration. She walked through brush and sat on grass the night before while attending an outdoor concert She is noted to have an erythematous, vesicular rash.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: According to the RUC E/M survey instrument for emergency medicine services, the service period is treated as a whole and includes the work from the time you initially review the patient's records until you complete their chart. In other words, pre and post service periods do not apply.

According to CPT "Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for the physicians to provide accurate estimates of the time spent face-to-face with a patient."

Description of Intra-Service Work:
-preparing to see the patient
- review records
- communicating with other professionals
-evaluation of a patient including
- an expanded problem focused history
- an expanded problem focused exam
- medical decision making of low complexity
-documentation of the medical record
-coordination of care
- telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient after discharge from the emergency department

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005
Presenter(s):	Dennis Beck, MD, FACEP
Specialty(s):	Emergency Medicine

CPT Code:	99282		
Sample Size:	320	Resp n: 101	Response: 31.56 %
Sample Type:	Panel		

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	0.52	0.75	1.00	1.22	2.50
Pre-Service Evaluation Time:			3.0		
Pre-Service Positioning Time:			0.0		
Pre-Service Scrub, Dress, Wait Time:			0.0		
Intra-Service Time:			10.00		

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	5.00	
Critical Care time/visit(s):	0.0	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	0.0	99238x 0.00 99239x 0.00
Office time/visit(s):	0.0	99211x 0.0 12x 0.0 13x 0.0 14x 0.0 15x 0.0

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
)9217	XXX	1.28

CPT Descriptor Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate]).

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

Other Reference CPT Code	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 36 **% of respondents:** 35 6 %

TIME ESTIMATES (Median)	**CPT Code: 99282**	**Key Reference CPT Code: 99217**
Median Pre-Service Time	3.00	
Median Intra-Service Time	10.00	
Median Immediate Post-service Time	5.00	
Median Critical Care Time	0.0	
Median Other Hospital Visit Time	0.0	
Median Discharge Day Management Time	0.0	
Median Office Visit Time	0.0	
Median Total Time	**18.00**	
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.13	2.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.01	2.41
Urgency of medical decision making	2.20	2.59

Technical Skill/Physical Effort (Mean)

Technical skill required	2.05	2.24
Physical effort required	1.88	1.91

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.11	2.21
Outcome depends on the skill and judgment of physician	2.18	2.32
Estimated risk of malpractice suit with poor outcome	2.40	2.24

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The majority of survey respondents indicated that the work associated with 99282 had not changed over the past ten years, however they recommended a RVW higher than the curent value of 0.55. We interpret this to mean that although they indicated that the work had not changed, they also believed the code was currently undervalued. It should be noted that this code has not previously been surveyed by the RUC.

ACEP recommends the survey median of 1.00 RVW for code 99282.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 27% No 72%

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) 88% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 3% no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 99282

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99283 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **2.00**
RUC RVU: **1.34**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, which requires these three key components: 1) an expanded problem focused 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 patients and/or family's needs. Usually, the presenting problem(s) are of moderate severity.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A previously well 8-year-old girl is presents to the emergency department because of fever, diarrhea, and crampy type abdominal pain. She appears to be hydrated, and there are no complaints of vomiting, dysuria or frequency. Her abdominal examination is not consistent with a surgical condition.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: According to the RUC E/M survey instrument for emergency medicine services, the service period is treated as a whole and includes the work from the time you initially review the patient's records until vou complete their chart. In other words, pre and post service periods do not apply.

According to CPT "Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for the physicians to provide accurate estimates of the time spent face-to-face with a patient."

Description of Intra-Service Work:
-preparing to see the patient
-review records
-communicating with other professionals, as appropriate
-evaluation of a patient including:
- an expanded problem focused history
- an expanded problem focused exam
- medical decision making of moderate complexity
-consideration of alternative diagnostic and treatment modalities
-reevaluation of patient as indicated
-reconsideration of likelihood of a surgical condition
-review of any diagnostics previously obtained and now available
-formulation and discussion of post-discharge plan with patient and/or family at time of discharge
- including initiation of medications
- dietary modifications
- follow-up with patient's established physician
-documentation of the medical record
coordination of care, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient after discharge from the emergency department

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005				
Presenter(s):	Dennis Beck, MD, FACEP				
Specialty(s):	Emergency Medicine				
CPT Code:	99283				
Sample Size: 320	**Resp n:** 101	**Response:** 31.56 %			
Sample Type:	Panel				

	Low	25th pctl	Median*	75th pctl	High
Survey RVW:	1.00	1.60	**2.00**	2.50	4.00
Pre-Service Evaluation Time:			**5.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:			**18.00**		

Post-Service	Total Min**	CPT code / # of visits
Immed. Post-time:	**7.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

*Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
)9234	XXX	2.56

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date 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 presenting problem(s) requiring admission are of low severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
CPT Descriptor 1		
MPC CPT Code 2	Global	Work RVU
CPT Descriptor 2		

)ther Reference CPT Code	Global	Work RVU
CPT Descriptor		

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 47 **% of respondents:** 46.5 %

TIME ESTIMATES (Median)	**CPT Code: 99283**	**Key Reference CPT Code: 99234**
Median Pre-Service Time	5.00	
Median Intra-Service Time	18.00	
Median Immediate Post-service Time	7.00	
Median Critical Care Time	0.0	
Median Other Hospital Visit Time	0.0	
Median Discharge Day Management Time	0.0	
Median Office Visit Time	0.0	
Median Total Time	**30.00**	
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.16
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.19	3.11
Urgency of medical decision making	3.39	3.20

Technical Skill/Physical Effort (Mean)

Technical skill required	3.11	3.13
Physical effort required	2.88	2 82

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.29	3.20
Outcome depends on the skill and judgment of physician	3.31	3.31
Estimated risk of malpractice suit with poor outcome	3.72	3.40

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

'hysician work involved in providing a 99283 service to a typical patient has increased since 1995 due to changes in the complexity of managing these patients as well as environmental changes in the healthcare system that have had a profound impact on our Emergency Departments. These environmental factors have directly increased physician work at the individual patient encounter level.

There has been a decline in the number of operating emergency departments and the volume of patients being served by the remaining existing facilities has increased. The CDC reports in its publication, CDC Advance Data Reports, National Hospital Ambulatory Medical Care Survey: Emergency Department Summary, that the number of ED visits between 1993 and 2003 increased by 26%, from 90.3 million to 113.9 million, while the number of hospital EDs in the United States decreased by 12.3% during the same period. In 2003, 10.3 million patients 75 years of age and over were seen in the ED, compared to 7.3 million in 1993. Uninsured patients using the emergency department as their source of primary care also contributed to the increase in volume of patients. According to the CDC, the number of uninsured patients rose from 12.7 million in 1993 to 16 million in 2003, the last year for which data is available. This translates to a 26% increase in the number of uninsured patient visits in the ED over the past ten years. This has resulted in a condition that has been aptly referred to as the "overcrowded emergency department."

As stated above, the increase in ED patient volume coupled with a decrease in the number of emergency departments has led to overcrowded conditions. According to a 2003 work study by ACEP with 933 emergency physicians responding, 88% reported moderate to severe crowding in their emergency departments. The largest contributors to overcrowding were cited as boarding of patients (84%) lack of inpatient staff (81%) and patients losing access to regular sources of medical care (71%). More than half (60%) of respondents reported their emergency departments boarded patients every day to several days per week. The majority (62%) said on average one to five patients are being boarded at any given time and more than 64% said these patients are being boarded from 4 to 12 hours.

The shortage of non-physician staff in many hospital emergency departments directly increases physician work. Crowding places increased psychological stress on the emergency physician as assessment, diagnostic, and treatment considerations must be made with fewer resources in terms of ancillary staff or immediate availability of diagnostic studies. Crowded conditions in the emergency department have significantly contributed to increased work associated with ED E/M codes.

CDC data also shows increases over the past five years (1999-2003) in the complexity and number of diagnostic and screening tests ordered, and medications prescribed for the typical ED patient. Medications were prescribed for 77.3% of all ED visits in 2003. The increase in the number of uninsured patients also increases work as such patients have typically not received routine health maintenance. They have substantially higher morbidity and mortality compared to insured patients with the same presenting complaint. All of these factors have increased the work for the physician providing the service during this period.

Current Documentation Guidelines were not in place 10 years ago. CPT policy and Documentation Guidelines regard every emergency department patient as a new patient. This places a disproportionate burden on the physician to both perform and document at a new patient level encounter for every patient they see, which requires an incremental increase from the work of ten years ago.

Considering the environmental and patient specific factors presented above, we believe the work involved in providing the typical emergency department E/M service has significantly increased. Therefore, we recommend the survey median of 2.00 RVWs for code 99283.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 88% No 11%

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) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 3% from inpatient to outpatient 13% no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 99283

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99284 Global Period: XXX Specialty Society RVU **3.14**
RUC RVU: **2.56**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, which requires these three key components: 1) a detailed history; 2) a detailed 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 patients 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

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year-old boy presents to the emergency department after sustaining a fall from his bicycle and hitting his head. He was observed to have a brief loss of consciousness and has vomited twice. He has a scalp hematoma, post-concussive behavior, and no evidence of other injuries.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: According to the RUC E/M survey instrument for emergency medicine services, the service period is treated as a whole and includes the work from the time you initially review the patient's records until you complete their chart. In other words, pre and post service periods do not apply.

According to CPT "Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for the physicians to provide accurate estimates of the time spent face-to-face with a patient."

Description of Intra-Service Work:
-preparing to see the patient
- review records
- communicating with other professionals including EMS personnel, as appropriate
-evaluation of patient including:
- a detailed history (portions of which may have to be deferred or obtained from someone other than the patient due to patient's head injury and age)
- a detailed examination
- decision making of moderate complexity
-consideration of alternative treatment modalities and implementation of a course of treatment
-consideration of possible diagnostics including imaging options and obtaining those deemed appropriate
-reconsideration of likelihood of a surgical condition
-reevaluation of patient after initial evaluation course of observation and/or treatment for head injury has been completed including supplemental history, new subjective elements, and reexamination
-consideration of further diagnostics and obtaining those deemed appropriate
reconsideration of alternative treatment modalities and implementation of a revised course of treatment as indicated by dditional information
-formulation and discussion of post-emergency department care plan with patient and/or family, and follow up as indicated with consultant or patient's established physician
-documentation of the medical record

-coordination of care, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient after discharge from the emergency department

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	Dennis Beck, MD, FACEP					
Specialty(s):	Emergency Medicine					
CPT Code:	99284					
Sample Size:	320	**Resp n:** 101		**Response:** 31.56 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.50	2.56	**3.14**	3.41	5.00
Pre-Service Evaluation Time:				**5.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:				**25.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**10.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15), 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99235	XXX	3.41

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date 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) requiring admission are of moderate severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 61 **% of respondents:** 60.4 %

TIME ESTIMATES (Median)	**CPT Code: 99284**	**Key Reference CPT Code: 99235**
Median Pre-Service Time	5.00	
Median Intra-Service Time	25.00	
Median Immediate Post-service Time	10.00	
Median Critical Care Time	0.0	
Median Other Hospital Visit Time	0.0	
Median Discharge Day Management Time	0.0	
Median Office Visit Time	0.0	
Median Total Time	**40.00**	
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.40	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.00
Urgency of medical decision making	4.40	4 10

Technical Skill/Physical Effort (Mean)

Technical skill required	4.10	4.00
Physical effort required	3.80	3.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.50	4.10
Outcome depends on the skill and judgment of physician	4.50	4.20
Estimated risk of malpractice suit with poor outcome	4.70	4.20

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

'hysician work involved in providing a 99284 service to a typical patient has increased since 1995 due to changes in the complexity of managing these patients as well as environmental changes in the healthcare system that have had a profound impact on our Emergency Departments. These environmental factors have directly increased physician work at the individual patient encounter level.

There has been a decline in the number of operating emergency departments and the volume of patients being served by the remaining existing facilities has increased. The CDC reports in its publication, CDC Advance Data Reports, National Hospital Ambulatory Medical Care Survey: Emergency Department Summary, that the number of ED visits between 1993 and 2003 increased by 26%, from 90.3 million to 113.9 million, while the number of hospital EDs in the United States decreased by 12.3% during the same period.. In 2003, 10.3 million patients 75 years of age and over were seen in the ED, compared to 7.3 million in 1993. Uninsured patients using the emergency department as their source of primary care also contributed to the increase in volume of patients. According to the CDC, the number of uninsured patients rose from 12.7 million in 1993 to 16 million in 2003, the last year for which data is available. This translates to a 26% increase in the number of uninsured patient visits in the ED over the past ten years. This has resulted in a condition that has been aptly referred to as the "overcrowded emergency department."

As stated above, the increase in ED patient volume coupled with a decrease in the number of emergency departments has led to overcrowded conditions. According to a 2003 work study by ACEP with 933 emergency physicians responding, 88% reported moderate to severe crowding in their emergency departments. The largest contributors to overcrowding were cited as boarding of patients (84%) lack of inpatient staff (81%) and patients losing access to regular sources of medical care (71%). More than half (60%) of respondents reported their emergency departments boarded patients every day to several days per week. The majority (62%) said on average one to five patients are being boarded at any given time and more than 64% said these patients are being boarded from 4 to 12 hours.

The shortage of non-physician staff in many hospital emergency departments directly increases physician work. Crowding places increased psychological stress on the emergency physician as difficult assessment, diagnostic, and treatment considerations must be made with fewer resources in terms of ancillary staff or immediate availability of diagnostic studies. Crowded conditions in the emergency department have significantly contributed to increased work associated with ED E/M codes.

The same research reported that nearly 50% of respondents indicated that their ED experienced a shortage of on-call physicians, especially for neurosurgery, plastic surgery, and orthopedics. In September 2003, CMS issued new regulations in an attempt to clarify certain provisions of the Emergency Medical Treatment and Labor ACT (EMTALA). An unanticipated result has been a dramatic exacerbation as far as lack of availability of on-call physicians and the difficulty experienced by emergency physicians in trying to find a specialist to accept patients for necessary specialty care. The delay or inability in finding an on-call specialist requires both more mental effort and judgment and technical skill from the emergency physician in evaluating and caring for a patient. In fact the physician work in coordinating care, arranging for physician treatment outside of the ED, arranging EMTALA transfers has increased significantly. The requirement to place HMO patients "in network" for follow up after the ED encounter also requires considerable physician work. Similar arrangements for follow up care can be even more challenging for the uninsured.

CDC data also shows increases over the past five years (1999-2003) in the complexity and number diagnostic and screening tests ordered, and medications prescribed for the typical ED patient. Medications were prescribed for 77.3% of all ED visits in 2003. The dramatic increase in treatment algorithms such as those for common presentations like acute coronary syndromes and stroke have also contributed to the complexity of physician work. The increase in the number of uninsured patients also increases work as such patients have typically not received routine health maintenance. They have substantially higher morbidity and mortality compared to insured patients with the same presenting complaint. There has also been a dramatic upturn in the number of acute psychiatric presentations to the ED which, when coupled with the decrease in psychiatric inpatient and outpatient resources, increases emergency physician work as far as assessment and disposition complexity and risk. All of these factors have increased the work for the physician providing the service during this period.

Services historically provided in the inpatient setting are now being rendered in an outpatient setting as admission criteria becomes more restrictive. This necessitates substantially more extensive work ups and greater efforts as far as coordination of care; thus requiring additional physician mental effort and judgment. The availability of more testing options has also increased the work associated with ED E/M services.

Current Documentation Guidelines were not in place 10 years ago. CPT policy and Documentation Guidelines regard every emergency department patient as a new patient. This places a disproportionate burden on the physician to both perform and document at a new patient level encounter for every patient they see, which requires an incremental

increase from the work of ten years ago. Also, the increased use of electronic health records in hospitals has created additional work for the physician as reviewing that database of previous medical records is now an expectation.

Considering the environmental and patient specific factors presented above, we believe the work involved in providing the typical emergency department E/M service has significantly increased. Therefore, we recommend the survey median of 3.14 RVWs for code 99284

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 96% No 3%

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) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 5% from inpatient to outpatient 24% no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 99284

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change:** **In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

Recommended Work Relative Value

CPT Code:99285 Global Period: XXX Specialty Society RVU: **4.19**

RUC RVU: **3.80**

CPT Descriptor: Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: 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 patients 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.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male patient presents to the emergency department via ambulance with the acute onset of chest pain compatible with cardiac ischemia. He has several cardiac risk factors. He appears anxious, has a sinus tachycardia and is mildly short of breath..

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: According to the RUC E/M survey instrument for emergency medicine services, the service period is treated as a whole and includes the work from the time you initially review the patient's records until you complete their chart. In other words, pre and post service periods do not apply.

According to CPT "Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for the physicians to provide accurate estimates of the time spent face-to-face with a patient."

Description of Intra-Service Work:
-preparing to see the patient
-reviewing records
-communicating with other professionals including EMS personnel, as appropriate
-evaluation of patient including:
- a comprehensive history (portions of which may have to be obtained from, or verified by, someone other than the patient due to patient's clinical condition)
- a comprehensive examination
- decision making of high complexity
-consideration of possible etiologies given patient's age, medical history, and current medications
-consideration of possible diagnostics and obtaining those deemed appropriate
-serial reevaluation of patient including new subjective elements, and physical examinations
-review of electronically available medical records including any diagnostics, previously obtained and now available
-consideration of further diagnostics and obtaining those deemed appropriate
-review of such further diagnostics when available
-consideration as to eligibility for immediate, time sensitive management options such as cardiac catheterization or aggressive medical treatment
-consideration of other specialty consultation
-discussion with patient's established physician
-obtaining other consultations as appropriate

-formulation and discussion of post-ED plan with patient and/or family
-documentation of the medical record
-coordination of care, and telephone calls with the patient, family members, or other health professionals associated with the delivery of care to this patient after discharge from the emergency department

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2005					
Presenter(s):	Dennis Beck, MD, FACEP					
Specialty(s):	Emergency Medicine					
CPT Code:	99285					
Sample Size:	320	**Resp n:** 101		**Response:** 31.56 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		1.80	3.80	**4.19**	4.50	7.00
Pre-Service Evaluation Time:				**8.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:				**40.00**		

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**15.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date 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) requiring admission are of high severity.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU

CPT Descriptor 2

Other Reference CPT Code Global Work RVU

CPT Descriptor

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 77 **% of respondents:** 76.2 %

TIME ESTIMATES (Median)	**CPT Code: 99285**	**Key Reference CPT Code: 99236**
Median Pre-Service Time	8.00	
Median Intra-Service Time	40.00	
Median Immediate Post-service Time	15 00	
Median Critical Care Time	0.0	
Median Other Hospital Visit Time	0.0	
Median Discharge Day Management Time	0.0	
Median Office Visit Time	0.0	
Median Total Time	**63.00**	
Other time if appropriate		

CPT Code:

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.90	4.70
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.90	4.87
Urgency of medical decision making	5.00	4.60

Technical Skill/Physical Effort (Mean)

Technical skill required	4.80	4.60
Physical effort required	4.50	4.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5.00	4.70
Outcome depends on the skill and judgment of physician	5.00	4.70
Estimated risk of malpractice suit with poor outcome	4.90	4.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity		
Intra-Service intensity/complexity		
Post-Service intensity/complexity		

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

Physician work involved in providing a 99285 service to a typical patient has increased since 1995 due to changes in the complexity of managing these patients as well as environmental changes in the healthcare system that have had a profound impact on our Emergency Departments. These environmental factors have directly increased physician work at the individual patient encounter level.

There has been a decline in the number of operating emergency departments and the volume of patients being served by the remaining existing facilities has increased. The CDC reports in its publication, CDC Advance Data Reports, National Hospital Ambulatory Medical Care Survey: Emergency Department Summary, that the number of ED visits between 1993 and 2003 increased by 26%, from 90.3 million to 113.9 million, while the number of hospital EDs in the United States decreased by 12.3% during the same period. In 2003, 10.3 million patients 75 years of age and over were seen in the ED, compared to 7.3 million in 1993. Uninsured patients using the emergency department as their source of primary care also contributed to the increase in volume of patients. According to the CDC, the number of uninsured patients rose from 12.7 million in 1993 to 16 million in 2003, the last year for which data is available. This translates to a 26% increase in the number of uninsured patient visits in the ED over the past ten years. This has resulted in a condition that has been aptly referred to as the "overcrowded emergency department."

As stated above, the increase in ED patient volume coupled with a decrease in the number of emergency departments has led to overcrowded conditions. According to a 2003 work study by ACEP with 933 emergency physicians responding, 88% reported moderate to severe crowding in their emergency departments. The largest contributors to overcrowding were cited as boarding of patients (84%) lack of inpatient staff (81%) and patients losing access to regular sources of medical care (71%). More than half (60%) of respondents reported their emergency departments boarded patients every day to several days per week. The majority (62%) said on average one to five patients are being boarded at any given time and more than 64% said these patients are being boarded from 4 to 12 hours.

When admitted patients are being boarded in the ED, the emergency physician ends up providing significant additional care that cannot be captured with other CPT codes and is incremental to the work of a 99285 as surveyed 10 years prior The shortage of non-physician staff in many hospital emergency departments directly increases physician work Crowding places increased psychological stress on the emergency physician as difficult assessment, diagnostic, and treatment considerations must be made with fewer resources in terms of ancillary staff or immediate availability of diagnostic studies. Crowded conditions in the emergency department have significantly contributed to increased work associated with ED E/M codes.

The same research reported that nearly 50% of respondents indicated that their ED experienced a shortage of on-call physicians, especially for neurosurgery, plastic surgery, and orthopedics. In September 2003, CMS issued new regulations in an attempt to clarify certain provisions of the Emergency Medical Treatment and Labor ACT (EMTALA). An unanticipated result has been a dramatic exacerbation as far as lack of availability of on-call physicians and the difficulty experienced by emergency physicians in trying to find a specialist to accept patients for necessary specialty care. The delay or inability in finding an on-call specialist requires both more mental effort and judgment and technical skill from the emergency physician in evaluating and caring for a patient. In fact the physician work in coordinating care, arranging for physician treatment outside of the ED, and arranging EMTALA transfers has increased significantly. The requirement to place HMO patients "in network" for follow up after the ED encounter also requires considerable physician work. Similar arrangements for follow up care can be even more challenging for the uninsured.

CDC data also shows increases over the past five years (1999-2003) in the complexity and number of diagnostic and screening tests ordered, and medications prescribed for the typical ED patient. Medications were prescribed for 77.3% of all ED visits in 2003. The dramatic increase in treatment algorithms such as those for common presentations such as acute coronary syndromes and stroke have also contributed to the complexity of physician work. The increase in the number of uninsured patients also increases work as such patients have typically not received routine health maintenance. They have substantially higher morbidity and mortality compared to insured patients with the same presenting complaint. There has also been a dramatic upturn in the number of acute psychiatric presentations to the ED which, when coupled with the decrease in psychiatric inpatient and outpatient resources, increases emergency physician work as far as assessment and disposition complexity and risk. All of these factors have increased the work for the physician providing the service during this period.

Services historically provided in the inpatient setting are now being rendered in an outpatient setting as admission criteria becomes more restrictive. This necessitates substantially more extensive work ups and greater efforts as far as coordination of care; thus requiring additional mental effort and judgment. The availability of more testing options has also increased the work associated with ED E/M services.

Current Documentation Guidelines were not in place 10 years ago. CPT policy and documentation guidelines regard every emergency department patient as a new patient. This places a disproportionate burden on the physician to both perform and document at a new patient level encounter for every patient they see, which requires an incremental increase from the work of ten years ago. Also, the increased use of electronic health records in hospitals has created additional work for the physician as reviewing that database of previous medical records is now an expectation.

Considering the environmental and patient specific factors presented above, we believe the work involved in providing the typical emergency department E/M service has significantly increased. Therefore, we recommend the survey median of 4.19 RVWs for code 99285.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 97% No 3%

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) 100% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient 5% from inpatient to outpatient 22% no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: 99285

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff type and ratios from above to compute new clinical staff intra assist physician time. The change in staff intra-assist physician time is the difference between the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99291 Global Period: XXX

Recommended Work Relative Value
Specialty Society RVU: **5.1**
RUC RVU: **4.29**

CPT Descriptor: Critical care, evaluation and management of the critically ill or injured patient; first 30 to 74 minutes

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CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female who, following hysterectomy, suffers an onset of severe dyspnea. Time spent 30 to 74 minutes. Services included in 99291 are: interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (eg, ECGs, blood pressure, hematologic data (99090); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilatory management (94656, 94657, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36540, 36600). Any services not listed are reported separately.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code?

Description of Pre-Service Work:
* Patient is critically ill. Review, assessment and integration of available data from multiple databases (eg, {not all inclusive} telemetry, central venous/intracardiac measurements of blood gases, as well as other diagnostic laboratory, radiological and nuclear medicine data in coorelation with the patient's signs, symptoms and reactions to therapeutic nterventions) and reading of films, rhythm strips, etc.
* Explanation of procedure(s)/service(s) bundled into critical care and not separately billable to patient/family members, outlining risks and benefits.

Description of Intra-Service Work:
*Patient is examined assessing all body systems.
* Consultations with nurses, respiratory therapists, nutritionists, physical therapists, pharmacists and other physicians
* Adjustments to ventilator settings; titration of fluid replacement; calculation of needed parenteral nutritional support, titration of amounts of vasoactives to maintain patient's blood pressure, and determining need for blood and volume expanders.
* Any necessary procedures are performed, and those not included in the list above, may be reported separately and the time to perform those procedures is NOT counted in critical care time.
* End-of-life discussions with surrogate decision-makers.

Description of Post-Service Work:
* A note is written describing the patient's critical illness, the critical care service provided including any procedures performed (bundled into critical care, and not separately billable), and the time (total time or start-stop time) spent.
* Notes may include explanations of interpretations of data and planned course of action
* Discussions with nurses, respiratory therapists, nutritionists, physical therapists, pharmacists and other physicians are often noted.
* Detailed instructions and orders are written for staff.
* Consultations with family members or surrogate decision makers are more frequent and complex than in other E/M services because of the severity of the patient's condition.
* High probability of imminent or life threatening deterioration in the patient's condition.
* Medically significant decisions for next 24 hours on-call, or until next subsequent hospital visit.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005				
Presenter(s):	Alan Plummer, MD, ATS and Edward Diamond, MD, ACCP				
Specialty(s):	Pulmonary Medicine				
CPT Code:	99291				
Sample Size: 284	**Resp n:** 80	**Response:** 28.16 %			
Sample Type:	Panel				
	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:	0.50	4.29	**5.10**	6.06	16.80
Pre-Service Evaluation Time:			**15.0**		
Pre-Service Positioning Time:			**0.0**		
Pre-Service Scrub, Dress, Wait Time:			**0.0**		
Intra-Service Time:	15.00	30 00	**40.00**	60 00	90 00

Post-Service	**Total Min****	**CPT code / # of visits**
Immed. Post-time:	**20.00**	
Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99236	XXX	4.26

CPT Descriptor Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires 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) requiring admission are of high severity

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
95810	XXX	3.52

CPT Descriptor 1 Polysomnography: sleep staging with 4 or more additional parameters of sleep, attended by a technologist

MPC CPT Code 2	Global	Work RVU
43260	000	5.95

CPT Descriptor 2 Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)

Other Reference CPT Code	Global	Work RVU
31629	000	4.09

CPT Descriptor Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 47 **% of respondents:** 58.7 %

TIME ESTIMATES (Median)	New/Revised CPT Code: 99291	Key Reference CPT Code: 99236
Median Pre-Service Time	15.00	0.00
Median Intra-Service Time	40.00	110.00
Median Immediate Post-service Time	20.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0 0	0.00
Median Total Time	**75.00**	**110.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4 80	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.74	3.89
Urgency of medical decision making	4.91	3.61

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	3.33
Physical effort required	3.98	2.92

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.89	3.55
Outcome depends on the skill and judgment of physician	4.79	3.85
Estimated risk of malpractice suit with poor outcome	4.47	3.62

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.77	3.14
Intra-Service intensity/complexity	4.83	3.85
Post-Service intensity/complexity	4.02	3.27

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ACCP and ATS staff worked on inputing one survey for both 99291, 99292 online on SurveyMonkey Data was split and analyzed. The American Thoracic Society's Clinical Practice Committee reviewed the data at their July 8, 2005 monthly meeting. The American College of Chest Physicians reviewed the data at their July 11, 2005 meeting. There was a total of 80 completed surveys, including 66 from ACCP and ATS (inc 1 respondent from SCCM), 6 (inc. 2 respondents from SCCM) from ASA, 7 from ASCO, and 1 from ASH. We were unable to segregate and compare data

from these other societies because the numbers were too small. Although several surgical specialties expressed interest in surveying this code, they conducted their own parallel survey process. As of the date of this submission, they were still attempting to collect, collate, analyze and interpret their data, so we were told.

Compelling Evidence: Eighty-six percent (86%) felt the work has changed, and of those 96% considered the patients to be more complex. We believe several lines of evidence compeling in justifying an increase in the wRVUs for this service.

First, consistency. Over the past decade, patients receiving critical care services have become increasingly complex. As an example, just delivery of mechanical ventilation has become far more complicated, with newer modes of ventilation (ie, pressure controlled ventilation, airway pressure release ventilation, independent lung ventilation, etc.), ventilator protocols with documented survival benefits (ie, low-stretch) or improved oxygenation (ie, prone positioning), and inhaled therapies (nitric oxide, prostacyclin) now more widely in use. A rising prevalence of immunosuppressed patients and resistant organisms have led to increasing difficulty in diagnosing life-threatening infections and to more complex antimicrobial regimens. In the last Five-Year Review, a multi-society coalition including trauma surgery presented survey data with a median in excess of 5 wRVUs. Therefore, an increase in wRVUs is clearly justified.

Second, in the May 3, 1996 Proposed Rule (p20033), it states, "If we assume that CPT code 99291 is the most intense service, we do not want the work RVUs for the other evaluation and management services to exceed 4.00. Under the current work RVUs, we have an established relationship between CPT code 99291 and CPT code 99213 (Level three established patient office visit). CPT code 99213 represents a service with 15 minutes of face-to-face time. CPT code 99291 represents an hour of service. We believe that four times the value for CPT code 99213 plus the work RVUs for ventilation management (1.22) and the interpretation of a single view chest x-ray (0.18) should be about equivalent to the work RVUs for critical care. We selected ventilation management and interpretation of a chest x-ray because they are the commonly performed items in critical care that are bundled into the critical care work RVUs." This means that the intensity level for critical care is derived from the bundled services. The services that are typically provided during critical care in 2005 differ from those listed in the 1996 Proposed Rule, and the values of the typically bundled services have changed, vent management has been considered by Workgroup #4 and is proposed to increase and that the intensity for crtical care should be higher than what CMS has previously assigned.

Third, as the anchor code for the E/M services, critical care should remain above the highest wRVUs assigned to the E/M services. The median survey value of 5.1 wRVUs would preserve this relationship, in comparison to the proposed increases for serveral of the E/M services to between 4 and 5 wRVUs in this Five-Year Review.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this new/revised code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this new/revised code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

Five-Year Review Specific Questions:

Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 86% No 14%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 1% I do not agree
B. Patients requiring this service are now:
   more complex (more work) 96% less complex (less work) no change
C. The usual site-of-service has changed:
   from outpatient to inpatient from inpatient to outpatient 2% no change

Addendum to RUC Summary of Recommendation Form
Five-Year Review of Physician Work
Resulting Practice Expense Direct Input Modifications

CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule - Utilize Report Provided by AMA Staff with Survey Packet)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time.	Staff % of Physician time 0%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		99238:	
Number and Level of Office Visits:		99211:	
		99212:	
		99213:	
		99214:	
		99215:	

Revised Time Data *(Base physician time data on new survey data and recommendations; use current staff typeand ratios from above to compute new clinical staff intra assist physician time. The change in staff intraassist physician time is the difference oetween the current and revised intra-assist physician time)*

Complete if Code is priced in the non-facility:			
Physician Intra-Service Time:			
Clinical Staff #1	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time** 0%
Clinical Staff #2	Staff Type:	Intra Assist Physician Time:	Staff % of Physician time **Change: In Time**
Complete if the global period is 010, or 090			
Discharge Day (none, ½, or full)		**99238:**	
Number and Level of Office Visits:		**99211:**	
		99212:	
		99213:	
		99214:	
		99215:	

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99292 Global Period: ZZZ

Recommended Work Relative Value
Specialty Society RVU: **2.66**
RUC RVU. **2.15**

CPT Descriptor: Critical care, evaluation and management of the critically ill or injured patient; each additional 30 minutes (List separately in addition to code for primary procedure) (Use 99292 in conjunction with 99291)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female who, following hysterectomy, suffers an onset of severe dyspnea. One half-hour segments of critical care time beyond the first 74 minutes.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Is conscious sedation inherent to this procedure? No Percent of survey respondents who stated it is typical?

Is conscious sedation inherent in your reference code? No

Description of Pre-Service Work: * No additional, incremental pre-service work.

Description of Intra-Service Work:
* Same intra-service work as 99291, but of longer duration: Patient is examined assessing all body systems. Consultations with nurses, respiratory therapists, nutritionists, physical therapists, pharmacists and other physicians. Adjustments to ventilator settings; titration of fluid replacement; calculation of needed parenteral nutritional support; titration of amounts of vasoactives to maintain patient's blood pressure, and determining need for blood and volume expanders. Any necessary procedures are performed, and those not included in the list above, may be reported separately and the time to perform those procedures is NOT counted in critical care time.

Description of Post-Service Work: * No additional, incremental post-service work.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	08/2005					
Presenter(s):	Alan Plummer, MD, ATS and Edward Diamond, MD, ACCP					
Specialty(s):	Pulmonary Medicine					
CPT Code:	99292					
Sample Size:	284	**Resp n:** 80		**Response:** 28.16 %		
Sample Type:	Panel					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Survey RVW:		0.50	2.00	**2.66**	3.50	8.40
Pre-Service Evaluation Time:				**0.0**		
Pre-Service Positioning Time:				**0.0**		
Pre-Service Scrub, Dress, Wait Time:				**0.0**		
Intra-Service Time:		10.00	30.00	**30.00**	30.00	60.00
Post-Service	**Total Min****	**CPT code / # of visits**				
Immed. Post-time:	**0.00**					

Critical Care time/visit(s):	**0.0**	99291x **0.0** 99292x **0.0**
Other Hospital time/visit(s):	**0.0**	99231x **0.0** 99232x **0.0** 99233x **0.0**
Discharge Day Mgmt:	**0.0**	99238x **0.00** 99239x **0.00**
Office time/visit(s):	**0.0**	99211x **0.0** 12x **0.0** 13x **0.0** 14x **0.0** 15x **0.0**

**Physician standard total minutes per E/M visit: 99291 (63); 99292 (32); 99233 (41); 99232 (30); 99231 (19); 99238 (36); 99215 (59); 99214 (38); 99213 (23); 99212 (15); 99211 (7).

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU
99356	ZZZ	1.71

CPT Descriptor Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour (List separately in addition to code for inpatient Evaluation and Management Service)

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU
20937	ZZZ	2.79

CPT Descriptor 1 Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision)

MPC CPT Code 2	Global	Work RVU
35600	ZZZ	4.94

CPT Descriptor 2 Harvest of upper extremity artery, one segment, for coronary artery bypass procedure

Other Reference CPT Code	Global	Work RVU
99354	ZZZ	1 77

CPT Descriptor Prolonged physician service in the office or other outpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (List separately in addition to code for office or other outpatient Evaluation and Management Service)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 29 **% of respondents:** 36.2 %

TIME ESTIMATES (Median)	**New/Revised CPT Code: 99292**	**Key Reference CPT Code: 99356**
Median Pre-Service Time	0.00	0.00
Median Intra-Service Time	30.00	60.00
Median Immediate Post-service Time	0.00	0.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Median Total Time	**30.00**	**60.00**
Other time if appropriate		

INTENSITY/COMPLEXITY MEASURES (Mean)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	4.53	3.32
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.62	3 64
Urgency of medical decision making	4.85	3 52

Technical Skill/Physical Effort (Mean)

Technical skill required	4.38	3 10
Physical effort required	3.83	2.83

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	5 99	5.90
Outcome depends on the skill and judgment of physician	4.76	3.68
Estimated risk of malpractice suit with poor outcome	4.34	3.39

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	4.73	3.72
Post-Service intensity/complexity	0.00	0.00

COMPELLING EVIDENCE RATIONALE (Required to be Completed)

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

ACCP and ATS staff worked on inputing one survey for both 99291, 99292 online on SurveyMonkey. Data was split nd analyzed. The American Thoracic Society's Clinical Practice Committee reviewed the data at their July 8, 2005 monthly meeting. The American College of Chest Physicians Practice Management Committee reviewed the data at their July 11, 2005 meeting. There was a total of 80 completed surveys. Compelling Evidence: In the May 3, 1996 Proposed Rule (p20033), it states, "If we assume that CPT code 99291 is the most intense service, we do not want the work RVUs for the other evaluation and management services to exceed 4.00. Under the current work RVUs, we have an established

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The intensity level for critical care is derived from the bundled services. Services that are typically provided during critical care in 2005 differ from those listed in the 1996 Proposed Rule, amd the values of the typically bundled services have changed, ventilation management has been considered by Workgroup #4 and is proposed to increase and that the intensity for critical care should be higher than what CMS has previously assigned.

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Please indicate the number of survey respondent percentages responding to each of the following questions (for example 0.05 = 5%):

Has the work of performing this service changed in the past 5 years? Yes 81% No 14%

A. This service represents new technology that has become more familiar (i.e., less work):
   I agree 1% I do not agree
B. Patients requiring this service are now:
   more complex (more work) 80% less complex (less work) no change
C. The usual site-of-service has changed:
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CPT Code: N/A

Current Time Data *(2005 Medicare Physician Payment Schedule – Utilize Report Provided by AMA Staff with Survey Packet)*

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Number and Level of Office Visits:		99211:	
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