

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
RUC RECOMMENDATIONS FOR 2012 MFS**

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December 20, 2010

Donald Berwick, MD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1503-FC, Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: CMS-1503-FC Medicare Program; Revisions to Payment Policies Under the Physician Payment Schedule and Other Revisions to Part B for CY 2011; Final Rule

Dear Administrator Berwick:

The American Medical Association (AMA)/Specialty Society RVS Update Committee (RUC) appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Final Rule on the revisions to Medicare payment policies under the Physician Payment Schedule for calendar year 2011, published in the November 29, 2010 *Federal Register*.

CMS has accepted 100% of the RUC's practice expense input recommendations with some technical refinements and has accepted 100% of the RUC recommended professional liability insurance crosswalks. However, CMS has accepted 85% of the RUC recommendations for physician work. A subset of these accepted recommendations was reduced for budget neutrality purposes. The RUC would like to thank CMS for the confidence it has displayed in our process of developing practice expense, professional liability insurance and work relative value recommendations for codes in the new and revised process and codes identified as potentially misvalued services. We hope that the following comments will provide enough clarity to the RUC recommendations for physician work that were rejected by CMS that you will reconsider your actions and affirm the RUC's recommended values.

#### **INTERIM VALUES – RECONSIDERATION OF RUC RECOMMENDATIONS**

##### ***Excision and Debridement***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim RVU
11042	Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square centimeters or less	1.12	0.80
11045	Debridement subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 square centimeters, or part thereof	0.69	0.33
11043	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 square centimeters or less	3.00	2.00
11046	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 square centimeters, or part thereof	1.29	0.70

11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 square centimeters or less	4.56	3.60
11047	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 square centimeters, or part thereof	2.00	1.20

**11042**

CMS mentions that the RUC reviewed compelling evidence for this service but does not acknowledge this evidence in its arguments for disagreeing with the RUC's recommendations. Therefore, the RUC would like to restate the arguments for CMS in order to inform their review. The RUC reviewed the compelling evidence argument made by the specialty societies. They indicated that in 2005, this service was not originally surveyed by podiatry and they are the dominant providers of the service, 40%, whereas general surgery represents 18%. Additionally, the RUC reviewed the RBRVS history of this code, including the fact that Harvard surveyed the codes with a 10-day global and then CMS (then HCFA) subsequently over several years reduced the work RVUs and changed the global period through the refinement process. Based on this argument, the RUC agreed that there was compelling evidence to consider a new work RVU for this service.

Secondly, for CPT code 11042, CMS indicates that the RUC recommended value was based on the old surveyed value. Although the RUC acknowledges that this RUC recommended value was a reaffirmation of the previous RUC HCPAC recommendation for this code, 1.12 work RVUs as valued during the 2005 Five Year Review, the RUC agreed that this was an appropriate valuation as it maintains relativity between the reference code and the surveyed code as the surveyed code has more intra-service time as compared to the reference code (15 minutes and 10 minutes, respectively). Further, the surveyed code requires more psychological stress, physical effort and mental effort and judgment to perform than the reference code. An additional reference code that the RUC agreed validated this recommended work RVU is MPC code 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU=1.10) as this reference code requires a similar amount of work to perform and has the same intra-service time, 15 minutes. **Based on these comparisons and the compelling evidence arguments, the RUC requests CMS accept the RUC recommendation of 1.12 work RVUs for 11042.**

**11045**

CMS states that they reduced the AMA RUC recommended value, 0.69 RVUs to 0.33 RVUs by removing the pre and post-service time from the interim final RVU for the primary procedure 11042 resulting in 0.33 RVUs. After a careful replication of this methodology, AMA staff observed that this resulting value should be 0.34 RVUs. Second, CMS assigned this value without offering any reference code to support this value. This lack of providing a reference code goes directly against comments made in this section of this Rule which state, "If we conclude that the AMA RUC's recommended value for a code was not accurate, we looked for comparisons with other established reference codes with clinical similarity or analogous pre-, post-, and intra-service times and where applicable, employed the building block approach to inform our interim final decision to establish an alternative value that we believe is more appropriate." We certainly appreciate CMS' dedication to keep the services within the RBRVS relative to one another. Thus, the RUC recommended value of 0.69 work RVUs for this service is supported by reference code 36575 *Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site* (work RVU=0.67) as this service

and the surveyed code have similar work RVUs and the same intra-service time, 15 minutes. **Based on these arguments, the RUC respectfully requests that CMS accept the RUC recommendation of 0.69 work RVUs for 11045.**

*11043, 11044, 11046 and 11047*

For all four of these services, CMS has rejected the RUC recommended value, which represents the 25<sup>th</sup> percentile and median of the survey data collected. CMS has recommended that the interim values for these services be equal to the survey low response. This methodology is flawed for several reasons. First, CMS states, “we found the weakest and least convincing valuations occurred in cases where the AMA RUC either deviated significantly or disregarded the survey results.” Although CMS criticizes the RUC for disregarding survey results, CMS proposes interim recommendations that ignore the survey results by selecting the survey low as an interim value. Second, it is acknowledged that the value representing the low of any survey could be construed as an outlier, the data representing one survey respondent. It is not appropriate for CMS to value services that will be performed by many based on the survey results of one survey respondent. Third, CMS offers no reference codes to support these interim values.

**Based on these arguments as well as those enumerated in the original RUC recommendations for these services, the RUC requests that CMS accept the RUC recommended values of 3.00 work RVUs for 11043, 4.56 work RVUs for 11044, 1.29 work RVUs for 11046 and 2.00 work RVUs for 11047.**

*Paraesophageal Hernia Repairs*

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
43283	Laparoscopy, surgical, esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty)	4.00	2.95
43327	Esophagogastric fundoplasty partial or complete; laparotomy	18.10	13.35
43328	Esophagogastric fundoplasty partial or complete; thoracotomy	27.00	19.91
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	26.60	19.62
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	30.00	21.46
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	30.00	22.12
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	33.00	23.97
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	35.00	25.81

43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	37.50	27.65
43338	Esophageal lengthening procedure (eg Collis gastroplasty or wedge gastroplasty)	3.00	2.21

The RUC would like to take this opportunity to address the CMS decision to apply budget neutrality to these services. The specialty societies indicated and the RUC agreed that there is compelling evidence that technology has changed the physician work to repair esophageal hernias. When the original paraesophageal hernia repair codes were introduced, they were meant to report anatomic defects within the diaphragm. Thus for many years, paraesophageal hernias were repaired by simply reducing the hernia contents below the diaphragm and narrowing the diaphragmatic crura with sutures to prevent re-herniation. These repairs were performed in an open fashion by either a transabdominal or transthoracic approach. Sometimes tacking sutures were used to fix the stomach to the abdominal wall or occasionally a gastrostomy tube was placed to fix the stomach in place so it would not re-herniate. Occasionally, strictures were dilated or concomitant ulcer disease was treated by vagotomy and pyloroplasty.

Because this was the era prior to modern anti-acid treatment with H2 histamine blockers and PPIs, esophageal strictures requiring treatment were frequent occurrences in paraesophageal hernia patients. In addition, ulcer disease of the stomach and duodenum was also commonly treated because *H. pylori* had not yet been recognized as an etiologic agent. It was therefore frequent to find giant paraesophageal hernias associated with concomitant strictures and/or ulcer disease. For these reasons, the diaphragmatic hernia repair codes were written to include concomitant treatment for strictures (with and without dilation) and ulcer disease (with or without vagotomy and pyloroplasty). However, in 2010, these treatments (dilation, V&P) are virtually never performed concomitantly with paraesophageal hernia repair, and thus the codes as written do not reflect current therapy.

Modern investigation has emphasized the importance of the lower esophageal sphincter's ability to generate pressure to prevent gastroesophageal reflux and the need to augment sphincter pressure with fundoplication, typically a 360 degree full wrap (Nissen) or a partial wrap (Belsey, Mark IV, Toupet). With this further understanding of the pathophysiology, these defects have now been reclassified as variants of hiatal hernia. The current coding schema is in direct opposition to this modern classification. The adjunctive surgical procedures of intraoperative dilatation, vagotomy, and pyloroplasty are now virtually never concomitantly performed with paraesophageal hernia repair; however, fundoplasty is almost always performed. Esophageal dilatation, if needed, is now done by gastroenterologists before any surgical procedure.

In summary, the work described by the current (to-be-deleted) codes was intended for patients with acid reflux (chemical symptoms) or blockage (mechanical symptoms). With the advent of medical management and less invasive treatments, the patients currently undergoing surgery are symptomatic, typically with blockage. The typical patient has more advanced disease and requires more complex repair.

The RUC agreed that there was sufficient compelling evidence to suggest that new values would be appropriate for these services. Further, these interim values create rank order anomalies with the vast majority of major inpatient surgical procedures as these values result in some of the

lowest intensities (0.035 for 43327 to 0.061 for 43335) in the entire RBRVS. **Based on these arguments, the RUC requests that CMS not apply budget neutrality to these services and accept the RUC recommended values.**

*43333 and 43335*

CMS assigned a value to both of these services by adjusting upward the RUC recommended values for codes without implantation of mesh by 2.50 work RVUs, an increment established in the RUC's valuation of 43337 and 43336. In other words, CMS added 2.50 work RVUs to the RUC recommended work RVUs of 26.60 RVUs for CPT code 43332 which resulted in a value of 29.10 for CPT code 43333. Further, CMS added 2.50 work RVUs to the RUC recommended work RVUs of 30.00 for CPT code 43334 which resulted in a value of 32.50 work RVUs for CPT code 43335.

The RUC respectfully disagrees with CMS' determination on these services, as first and foremost, these new values are not supported by the survey results or RUC recommendations, which were not derived by such a building block methodology. The RUC evaluated the differential values as part of their robust consideration of the survey results, and found the magnitude estimation of the survey respondents supportive, providing correct rank order and dispersion for these codes. This is an extremely important point, in that magnitude estimation produces a value for all the physician work, which includes work related to inserting mesh as well as other patient factors that in turn make the insertion of mesh necessary. Choosing an abdominal, thoracic, or thoraco-abdominal approach and whether or not mesh will be required is integrally related to the patient's condition, and all should be valued according to the total surveyed work and not trivially adjusted. The RUC would argue that the incremental differences between these services should not be the same as evidenced by the survey data collected by the specialty. In addition, The RUC would also like to note that CMS proposes these interim values without the support of reference codes within the RBRVS. **The RUC requests that CMS accept the RUC recommended survey median values, 30.00 work RVUs for 43333 and 33.00 work RVUs for 43335.**

*Vaginal Radiation Afterloading Apparatus for Clinical Brachytherapy*

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	5.40	3.37
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	2.69	1.87

**57155**

CMS has stated that the method used to derive the value of this service lacked a defined logic. Therefore, CMS proposes an interim value of 3.37 RVUs which is a crosswalk from 58823 *Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)*. The RUC would like to offer several comments regarding this determination. First, CMS expresses concern in the Final Rule about the RUC valuing a service based on crosswalking it to another service without survey data to support the recommended value. Therefore, the RUC does not understand why CMS would value a service using this methodology. Second, the RUC at this time would like to clarify the recommendation submitted to CMS. To determine a value

for this service, the RUC reviewed several services with similar physician work and time, including: 50382 *Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (000 global, work RVU = 5.50, 60 minutes intra-service) and 52001 *Cystourethroscopy with irrigation and evacuation of multiple obstructing clots* (000 global, work RVU = 5.44, 60 minutes intra-service). Based on the above RUC reviewed comparison services, the RUC agreed that a value of 5.40 work relative value units would appropriately rank order 57155 within the radiation oncology family of services and across specialties. **Based on this rationale, the RUC requests that CMS accept the RUC recommended value of 5.40 RVUs for 57155.**

#### 57156

CMS has stated that because of the reductions made to 57185, a related code, they believe the value of 57156 should be reduced. CMS proposes an interim value of 1.87 RVUs which is a crosswalk from 62319 *Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)*. The RUC would like to offer several comments regarding this determination. First, the RUC assumes that CMS was referring to the proposed reductions in CPT code 57155, as CPT code 57185 does not exist. Second, CMS expresses concern in the Final Rule about the RUC valuing a service based on crosswalking it to another service without survey data to support the recommended value. Therefore, the RUC does not understand why CMS would value a service using this methodology.

To validate the RUC recommended value for this service, 2.69 RVUs, the survey's 25<sup>th</sup> percentile, the RUC reviewed the survey's key reference service 19296 *Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy (work RVU = 3.63, 000 day global, 30 minutes intra-service time)* as a comparable service and agreed that it was a more difficult and time consuming service than the surveyed code. The RUC reviewed additional services with similar physician work and time, including; MPC code 45378 *Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)* (000 day global, work RVU = 3.69, 30 minutes intra-service) and 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (000 day global, work RVU= 2.78, 30 minutes of intra-service time).

**Based on this rationale, the RUC requests that CMS accept the RUC recommended value of 2.69 RVUs for 57156.**

#### Vagus Nerve Stimulator

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	6.44	6.05

64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	11.19	9.00
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	15.00	11.00
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	13.00	9.10

For 61885 and 64568, CMS stated the method used to establish the AMA RUC recommended value lacked a defined logic and an appropriately vigorous methodology was not used. For 64569 and 64570, CMS stated that they are proposing revised interim values to maintain relativity with the proposed interim values for 61885 and 64568. Therefore, CMS selected the survey 25<sup>th</sup> percentile value for all of these services. The RUC would like to comment on the RUC methodology used to derive values for these services. The RUC discussed these codes at length discussing most importantly their relativity to other similar services. Therefore, the RUC provided several reference codes for each service and based valuation of these services on these reference points.

The RUC compared 61885 to 49585 *Repair umbilical hernia, age 5 years or older; reducible* (work RVU = 6.59, intra time = 45 minutes). This code has similar intra-service work and similar post operative physician work. Additionally, code 43888 *Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only* (work RVU = 6.44, intra time = 45 minutes) was compared to the surveyed service and the RUC agreed that this reference service, with an RVU of 6.44, properly approximates the intensity and complexity of 61885 and demonstrates appropriate relative work value amongst all physician services.

The RUC compared 64568 to 63655 *Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural* (work RVU = 11.56 and total time = 273 minutes), 26260 *Radical resection of tumor, proximal or middle phalanx of finger* (work RVU = 11.16 and total time = 256 minutes) and 58660 *Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis)* (work RVU = 11.59, total time = 209.5 minutes). The RUC came to a consensus that these services accurately portray similar physician intra-service work with analogous work intensity and complexity.

The RUC compared 64569 to the key reference code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda quine and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU = 15.37 and total time = 362 minutes). The RUC found that while the reference code has 50 more minutes of total time, 64569 has 120 minutes intra-service time compared to 90 minutes for 63047. The median survey work RVU of 15.00 was chosen as it accurately aligns itself in relation to similar physician services.

The RUC compared 64570 to the key reference code 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda quine and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU = 15.37 and total time = 362 minutes). The RUC noted that while both services have 90 minutes of intra-service time, 63047 has significantly more total time due to a greater number of post operative visits, 362 minutes compared to 282 minutes for 64570. Given this gap in time and intensity, the

median survey work RVU of 13.00 was chosen as it accurately aligns itself in relation to similar physician services.

CMS, throughout the Final Rule, makes its interim recommendations based on the selection of a reference code which has similar time and intensity. Therefore, it is perplexing to the RUC, that CMS would not find logic in the RUC employing this same methodology to value services such as in the instances of the valuation of 61885 and 64568. Further, CMS does not offer any reference codes to support the proposed interim values for any of these services. **Based on these arguments, The RUC requests that CMS accept the RUC recommended value of 6.44 RVUs for 61885, 11.19 for 64568, 15.00 for 64569 and 13.00 for 64570.**

***Ultrasound of Extremity***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	0.72	0.59
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited anatomic specific	0.50	0.41

CMS disagreed with the RUC recommendations for these services and proposes to cap the value of 76881 to the value of the existing code for this service, 76880. For 76882, CMS assigns a value based on a mathematical computation which maintains the relationship between the RUC recommended values for 76881 and 76882.

The RUC appreciates the opportunity to clarify its recommendations for these services. First and foremost, the RUC would like to clarify the reporting of these services for 2011. The CPT Editorial Panel deleted 76880 and created two new codes to distinguish between the comprehensive diagnostic ultrasound and the focused anatomic-specific ultrasound. It must be understood that the utilization for the deleted code is now reported under 76881 and 76882. Based on the analysis of the Medicare claims data which indicated that podiatry was the dominant provider of 76880, the American Podiatric Medical Association acknowledged that they more commonly perform a limited ultrasound examination, which will now be reported as 76882. In other words, the services that are currently reported using code 76880 will actually be reported more commonly with 76882, not 76881. Understanding this utilization shift, the RUC's recommendation for these two codes resulted in an overall work savings. CMS did not acknowledge this overall impact in the Final Rule and merely indicated there concern about the potential increase in work RVUs for 76881.

Second, the RUC had a robust discussion concerning the valuation of 76881. The RUC recognized and agreed with the compelling evidence presented by the specialty societies that there had been a change in the typical provider, the site of service, and the ultrasound technology. Further, the RUC agreed that the patient population is different, whereas there are more evaluations of musculoskeletal pathology using more advanced ultrasound technology rather than magnetic resonance imaging. Ultrasound provides a high level of diagnostic accuracy as well as the potential for dynamic evaluation while at the same time being a non-invasive modality that involves no radiation. Given this information, the RUC agreed there was sufficient evidence to support a different value than the current value for the deleted 76880. CMS did not acknowledge

the compelling evidence arguments given in the RUC recommendations, therefore we appreciate the opportunity to convey them again.

Third, the RUC added 76881 and 76882 to the New Technology List. The RUC requested the retrospective review because would like to ensure that the utilization data assumption that 76880 will now be more commonly reported with 76882 and not 76881 is correct. The RUC is committed to obtaining reliable data and ensuring that data is accurate in the future.

**Based on these arguments, the RUC requests that CMS accept the RUC recommended values of 0.72 RVUs for 76881 and 0.50 RVUs for 76882.**

***Evaluation of Fine Needle Aspirate***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
88172	<i>Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, first evaluation episode, each site</i>	0.69	0.60

The RUC respectfully disagrees with the CMS determination that the current work RVU for this service should be maintained at 0.60 work RVUs. CMS states that although this code descriptor has been revised, no explanation was provided by the RUC to demonstrate and increase in physician work. Again, the RUC would like to clarify the reporting of this service. CPT code 88172 is currently used to report each episode of cytopathology of fine needle aspirate. This code was revised to report the first evaluation episode and CPT code 88177 *Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site* (RUC recommended work RVU=0.42) was added to report each additional episode of cytopathology evaluation of fine needle aspirate. Therefore, some of the utilization of 88172 will shift to 88177. This new reporting mechanism allows for proper reporting and valuation of the services as the RUC agreed with the specialty society that the first evaluation episode was much more intense than the subsequent episodes.

The RUC understood this new reporting mechanism and agrees with CMS, that there was no compelling evidence offered to change the overall value of the services as now defined in CPT. Therefore, the recommendations made to CMS were considered to be work neutral. CMS is proposing an overall decrease with the interim values published in the Final Rule with no evidence to support this decrease including no reference code to substantiate the proposed interim value of 88172. **Based on these arguments, the RUC requests that CMS accept the RUC recommended value for 88172, 0.69 RVUs.**

***Immunization Administration***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
90460	Immunization Administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care profession; first vaccine/toxoid component	0.20	0.17
90461	Immunization Administration through 18 years of age via any route of administration, with counseling by physician or other qualified health profession; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)	0.16	0.15

CMS is proposing to assign work RVUs for these services based on the work RVUs assigned to the current immunization administration codes since the new codes would be billed on a per toxoid basis in 2011. The RUC has significant concern with this determination as this issue was discussed at length. The specialty society presented compelling evidence that the physician time has changed in performing these services by providing rationale for an increasing frequency of counseling necessary to convince parents to 1) immunize their children at all; and 2) to persuade them of the safety and efficacy of component vaccines. Increased attention to vaccine safety on the Internet and in other media has driven parental anxiety and has necessitated additional physician involvement and discussion with parents. The RUC agreed that this increased physician work should be recognized.

The specialty society presented that the typical patient receives two vaccinations in one visit. However, based upon the age of the patient and specific vaccines available, some visits require only one unit of 90460, some visits require one or more units of 90460 and one or more units of 90461. It was noted that higher multiples of reporting of these codes would occur at infrequent visits (primarily 2 month, 6 months, and 4 years of age) and any payor concern regarding coding and valuation with these outlier visits may be addressed with a limit on the number of 90461 units allowed. The RUC was convinced that this information as presented by the specialty society was accurate and reasonable. Further, the RUC agreed that the increases in the work RVUs for these services compared to the current codes, as supported by the reference codes provided in the RUC rationales, were appropriate.

It should be noted that the rationale for revising the immunization administration codes was based on the fact that the per administration predecessor codes did not allow physicians to accurately report the considerable work involved in counseling for combination vaccines (i.e., those vaccines with more than one component). The new codes represent a substantial structural revision from their predecessor codes in that they allow reporting of counseling per vaccine component rather than per administration. It is inappropriate to crosswalk values from predecessor codes to the new codes given the underlying structural differences between the two sets of codes. Furthermore, CMS's crosswalk valuation for the new codes would make the relative value of physician work equivalent to other immunization administration codes (i.e., 90471-90472), which do not have the requirement of physician counseling as part of their descriptors.

**Based on these arguments, the RUC requests that CMS accept the RUC recommended value of 0.20 RVUs for 90460 and 0.16 RVUs for 90461.**

***Diabetic Retinopathy Imaging***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	0.44	0.30

For this service, CMS has rejected the RUC recommended value, which represents the 25<sup>th</sup> percentile of the survey data collected. CMS has recommended that the interim value for this service be equal to the survey low. This methodology is flawed for several reasons. First, CMS states, “we found the weakest and least convincing valuations occurred in cases where the AMA RUC either deviated significantly or disregarded the survey results.” Although CMS criticizes the RUC for disregarding survey results, CMS proposes interim recommendations that ignore the survey results by selecting the survey low as an interim value. Second, it is acknowledged that the value representing the low of any survey could be construed as an outlier, the data representing one survey respondent. It is not appropriate for CMS to value services that will be performed by many based on the survey results of one survey respondent.

It should also be noted that the RUC compared this service to 92250 *Fundus photography with interpretation and report* (work RVU = 0.44, 9 minutes of intra-service time and 5 minutes immediate post). The RUC agreed with the specialty society that these two services were virtually identical in physician work, time, and intensity and should be valued the same as the only difference between the services is that 92250 is performed in the office and 92228 is performed remotely. The RUC agrees that valuing these services differently would create a rank order anomaly as these services represent the same physician work. Further, CMS selects 92135 Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral (Work RVU=0.35) as a reference code. The RUC agrees that this reference code is not appropriate as it is being deleted for 2011 and furthermore, being replaced with higher valued services, 92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve (CMS Interim Work RVU=0.50) or 92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve (CMS Interim Work RVU=0.50). **Based on these arguments as well as those enumerated in the original RUC recommendations for these services, the RUC requests that CMS accept the RUC recommended value of 0.44 work RVUs for 92228.**

***Subsequent Hospital Observation Care***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
99224	Subsequent observation care, per day, for the evaluation and management of a patient	0.76	0.54

99225	Subsequent observation care, per day, for the evaluation and management of a patient,	1.39	0.96
99226	Subsequent observation care, per day, for the evaluation and management of a patient,	2.00	1.44

CMS has rejected the RUC recommended values for these services stating that, to recognize the differences in the patient acuity between the facility and non-facility settings, they have removed the pre- and post-service times and corresponding work RVUs from the RUC recommended values, reducing the values to approximately 75% of the values for the subsequent hospital care codes.

The RUC appreciates the opportunity to comment on these interim values proposed by CMS. First and foremost, the RUC adamantly disagrees with the notion stated by CMS that the acuity level of the typical patient receiving outpatient observation services would generally be lower than that of the inpatient level. The RUC carefully considered the typical patient as described by the specialties and agreed they were comparable to those described in the subsequent hospital care codes. According to the specialty society's survey data, a large percentage of their survey respondents thought that the typical patient as described by specialty society was representative of the service. However, the specialties indicated that those survey respondents who disagreed with the typical patient indicated that their patients would be more complex (eg more comorbidities) and/or have a different presenting problem (eg cardiac, gastrointestinal, respiratory). This information implies to the RUC that patients receiving these services are equally as intense as those patient receiving inpatient treatment.

Second, the RUC agrees that whether the patient is in observation status or admitted to the hospital, the work provided by the physician is the same. This notion is supported by the survey data collected by the specialty societies. In all three codes, the reference code most selected by the survey respondents was the corresponding subsequent hospital care code. Further, the survey data demonstrated that the times and intensities of the hospital care codes and the subsequent observation codes were comparable. The RUC recommended values for these services, the 25<sup>th</sup> percentile, reflect this survey data. The RUC agrees that CMS should not employ a method of evaluating services by discounting the input of the physicians who provide these services and partook in the RUC survey process. It is not appropriate that CMS would take this action when earlier in the Final Rule CMS states, "we found the weakest and least convincing valuations occurred in cases where the AMA RUC either deviated significantly or disregarded the survey results." Further, CMS offers no reference code to support the imputed interim values for these services.

Finally, we take exception to how the agency has attempted to value these subsequent observation codes. Removing the pre- and post-service time of each implies there is no such time or physician work involved, and it implies that subsequent observation care only involves face-to-face time with the patient. The reality is that subsequent observation care does involve physician time and work both before and after the encounter, just as almost all evaluation and management services do. Setting aside the acuity issue momentarily, we note that subsequent hospital codes 99231-99233 all involve pre- and post-service physician time and work. Even if patients in observation status were less acute, the need for pre- and post-service time and work would not simply disappear, as CMS suggests that it would.

**Based on these arguments, the RUC respectfully requests that CMS accept the RUC recommended values for these services, 0.76 RVUs for 99224, 1.39 RVUs for 99225 and 2.00 RVUs 99226.**

Similar to the relationship the RUC established between the subsequent observation care codes and the subsequent hospital care codes, the RUC just reviewed the relationship between the inpatient observation visits (99218-99210) and the inpatient hospital care codes (99221-99223) at the 2010 Five-Year Review. The RUC determined that the initial observation codes should be valued equivalent to the corresponding initial hospital care codes since the levels of history, exam and medical decision making correspond in each instance. CMS should consider these RUC recommendations together and should support the relationships that the RUC established.

### Diagnostic Cardiac Catheterization

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	3.02	2.72
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	4.32	4.75
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	5.98	6.24
93454	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	4.95	4.79
93455	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	6.15	5.54
93456	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	6.00	6.15
93457	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	7.66	6.89
93458	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	6.51	5.85

93459	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	7.34	6.60
93460	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	7.88	7.35
93461	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	9.00	8.10
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture(List separately in addition to code for primary procedure)	3.73	3.73
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) and repeat hemodynamic measurements	2.00	2.00
93464	Physiologic exercise study (eg, bicycle or arm ergometry, or pharmacologic exercise) and repeat hemodynamic measurements	1.80	1.80
93563	Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization	2.00	1.11
93564	Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed	2.10	1.13
93565	Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective left ventricular or left atrial angiography	1.90	0.86
93566	Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective right ventricular or right atrial angiography	0.96	0.86

93567	Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for supravalvular aortography	0.97	0.97
93568	Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for pulmonary angiography	0.98	0.88

CMS rejected the RUC recommended values for all of the diagnostic cardiac catheterization services stating that these recommended values represent negligible work efficiencies gained in the bundling of these services. To establish interim values for these services, CMS applied a 10 percent reduction to the sum of the current work RVUS for the component codes, taking into account any multiple procedure reduction that would apply under current CMS policy. Further, CMS requests that the RUC re-review the valuation for these services.

The RUC appreciates the opportunity to comment on the RUC's recommendations for the diagnostic cardiac catheterization services. The RUC agrees that the valuation history of these codes needs to be established to understand the RUC's recommendations. In 1993, the diagnostic cardiac catheterization codes could be reported either through a bundled mechanism or a component coding mechanism. The CMS valuation for both mechanisms was virtually the same. In 1994, the diagnostic cardiac catheterization codes were deleted and a new component coding structure was designed. Between 1994 and 2010, the valuation for the component coding for this service was subject to minor adjustments that were applied to all values within the RBRVS, as well as some modifications in multiple procedure payment policy. The following is an example of the valuation history for a left heart catheterization combination service between 1993 and 2010:

LHC Combo	1993 Bundled (RVUs)	1993 Component (RVUs)	1994 Component (RVUs)	2010 Component (RVUs)	2011 Bundled (RUC Recommended RVUs)
	93547 (4.97)	93510 (4.38)	93510 (4.38)	93510 (4.32)	93458 (6.51)
		93543 (0.29)	93543 (0.29)	93543 (0.15)*	
		93545 (0.29)	93545 (0.29)	93545 (0.40)	
	75754 (1.35)	75754 (1.35)	93555 (0.82)	93555 (0.81)	
			93556 (0.84)	93556 (0.83)	
Total Work RVUs	6.32 RVUs	6.31 RVUs	6.62 RVUs	6.51 RVUs	6.51 RVUs

\*Valuation subject to Multiple Procedure Reduction Policy which went into effect in 1995

This valuation history suggests that CMS ensured that there was no duplication in the valuation of these services when reported by component in the initiation of the RBRVS. The RUC reviewed the new code based on magnitude estimation, while reviewing the existing valuation and also determine that duplication of resources were not an issue for this particular family of services. Continuing the example from above, the RUC recommendation for the 2011 bundled code for the LHC combo is 93458 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, is 6.51 RVUs.

The RUC acknowledges that it did not include the valuation history of the diagnostic cardiac catheterization in its recommendations to CMS. The RUC, at the request of CMS, will convene a workgroup to review the RUC's recommendations for these services. The Workgroup will carefully consider the valuation history of these services and ensure that when the final recommendations are submitted to CMS, this valuation history is submitted as well.

The RUC spent a great deal of time to ensure that the recommended values for these codes are accurate. The specialty society conducted two surveys to make certain that the survey sample for these codes was representative of the national providers of this service. The RUC conducted an extensive review over several conference calls, facilitation committee meetings and two RUC meetings. Each code was valued utilizing magnitude estimation to a relevant reference code to ensure that the value recommended was relative to other services within the RBRVS. All this being said, the RUC will convene a workgroup to re-assess the recommendations submitted in May 2010 and provide CMS comprehensive rationales to support its final recommendations.

### ***Control Nasal Hemorrhage***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	1.21	1.10

CMS rejected the RUC recommended value of 1.21 RVUs, the current value of the service and has proposed the survey 25<sup>th</sup> percentile, 1.10 RVUs as an interim value for 30901. CMS provides no reference code to support the proposed interim value. The RUC reviewed the specialty society survey data and agreed with the specialty society that there is no compelling evidence to change the current work RVU of 1.21. To support the current valuation, the RUC compared 30901 to CPT code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU = 1.15) and agreed that 30901 required slightly more total service time to perform, 26 minutes and 22 minutes, respectively and 30901 and required comparable intensity and complexity. The RUC also compared 30901 to the key reference code 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* (work RVU = 1.10) and agreed that code 30901 would be relatively more intense/complex because it involves an active process requiring immediate therapeutic attention compared with 31231 which is a scheduled diagnostic procedure. **Based on this rationale, the RUC requests that CMS accept the RUC recommended values for this service, 1.21 RVUs for 30901.**

**Cystourethroscopy**

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	2.80	2.60
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	2.83	1.47

CMS has rejected the RUC recommended values for these services, the current work RVU and is recommending the 25<sup>th</sup> percentile of the survey data based on significant reductions to the pre-service time as recommended by the RUC. CMS has provided no reference codes to support these interim values.

The RUC understands that the specialty society has already expressed a comment for the technical correction that the 25<sup>th</sup> percentile for 52332 was 3.20 RVUs not 1.47 RVUs as stated in the *Final Rule*.

The RUC acknowledges that the specialties recommended significant reductions to the pre-service times currently associated with these services. These reductions in time were made in part to conform to the RUC's pre-service time packages. These packages were instituted to provide a standard approach for the RUC to review pre-service times recommended by specialty societies. They were not instituted to be used as part of a methodology to systematically remove RVUs from services whose recommendations are based on magnitude estimation. The RUC agreed that for both of these services, there was no compelling evidence offered that indicated that the work for these services had changed. For additional support, the RUC provided reference codes with similar times and intensities to justify the current value of these services. **Based on these arguments, the RUC requests that CMS accept the RUC recommended values for these services, 2.80 RVUs for 52281 and 2.83 RVUs for 52232.**

**Obstetrical Care Services**

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	32.69	28.69
59409	Vaginal delivery only (with or without episiotomy and/or forceps);	14.37	12.82
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	18.54	16.07
59412	External cephalic version, with or without tocolysis	1.71	1.53
59414	Delivery of placenta	1.61	1.44
59425	Antepartum care only; 4-6 visits	6.31	5.63

59426	Antepartum care only; 7 or more visits	11.16	9.96
59430	Postpartum care only	2.47	2.20
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care	36.17	31.80
59514	Cesarean delivery only;	16.13	14.39
59515	Cesarean delivery only; including postpartum care	22.00	19.15
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	34.40	30.22
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);	16.09	14.35
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	20.26	17.60
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	36.69	32.26
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;	16.66	14.86
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care	22.53	19.63

CMS applied budget neutrality to all the obstetrical care codes 59400-59622. Additionally, CMS has proposed to further reduce the RUC recommended values for these codes by altering the RUC recommended building block to include a 99213 office visit proxy instead of the RUC recommended office proxy of a 99214 office visit for the first post-partum visit.

The RUC appreciates this opportunity to clarify its recommendations for these services. First, to address the CMS proposal that these service should be subject to budget neutrality, the RUC would like to offer the following comments. The RUC carefully reviewed the work RVU history of these codes and determined that for two of the obstetrical care base codes, 59400 and 59510, the existing work RVUs were based on a building block established by CMS. The specialty societies reviewed the building block as outlined in the *Final Rule* published on December 2, 1993, and were unable to replicate it. Further, the building block did not account for any discharge day management for the patient. As all of these codes were valued based on building blocks between each other, the RUC was compelled to believe that incorrect assumptions were used to develop the current work RVUs associated with these procedures, with the exception of CPT codes 59412 *External cephalic version, with or without tocolysis* and 59414 *Delivery of placenta (separate procedure)*. It should also be noted that these services are not predominately performed in the Medicare population and that subjecting them to the Medicare constraints of budget neutrality significantly distorts the appropriate value of these services.

Further, the building blocks that CMS used to develop work RVUs for 59400 and 59510 included evaluation and management services. The obstetrical care codes have not been re-reviewed based on a building block of evaluation and management codes, which have had significant RVU increases in the past 17 years. CMS, in its discussion about these services, did not acknowledge either one of these compelling evidence arguments provided by the RUC nor justify the building block that was used by CMS to develop the work RVUs for these services. **Based on these**

**arguments, the RUC agrees that budget neutrality should not be applied and urges CMS to accept the RUC recommended values for these services.**

Second, although 59412 and 59414 have a MMM global period, they are typically performed as separate procedures. The RUC agreed that there was no compelling evidence to increase the RVU associated with these procedures and recommended that the work and service time survey values for these services supports their existing values. The RUC agreed to maintain the existing values of these services and recommends the surveyed times and service descriptions be used in the RUC database. CMS has recommended interim values which are lower than the current value for these services, stating that they should be subject to budget neutrality without supplying any evidence to support a lower value. **The RUC agrees that CMS should reconsider its interim values for these services based on this rationale and accept the RUC recommended values for these services, 1.71 RVUs for 59412 and 1.61 RVUs for 59414.**

Third, to address the CMS proposal to alter the RUC recommended building block utilized in developing work RVUs for the services listed above, the RUC offers the following comments. The RUC had lengthy discussion about the components of the building block used to develop recommendations for these services, specifically the post-partum visit that occurs 6 weeks after delivery. The specialty society explained that the physician activities include not only a post-procedure physical exam of the abdomen, breasts and external genitalia including the perineum but also the physician provides counseling on contraceptives, screens for post-partum depression, discusses physical symptoms, breast feeding, resuming sexual activities, diet and exercise. Given the amount of services provided by the physician at this visit, the RUC agreed that a 99214 office visit best approximated this service. Therefore, based on these arguments, the RUC strongly disagrees with the CMS proposal to change the RUC recommended building block to include a 99213 office visit for the 6 week post-partum visit instead of a 99214 office visit. **The RUC strongly urges CMS to accept the RUC recommended values for all of the obstetrical care services.**

***Transforaminal Epidural Injection***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with image guidance (fluoroscopy or CT), lumbar or sacral; single level	1.90	1.75

CMS rejected the RUC recommended value for this service and proposed an interim value equivalent to the 25<sup>th</sup> percentile of the RUC survey data. CMS provides no reference to justify this interim value. The RUC compared 64483 to MPC service 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and pre-time 25 minutes, intra-time 15 minutes and post-time 5 minutes) which requires similar physician time and work to perform. Therefore, the RUC agrees that this reference code supports a work RVU of 1.90 for code 64483.

Additionally, the RUC noted that a work RVU of 1.90 for 64483 was appropriately more intense than 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral;*

*single level* (work RVU = 1.52 and 17 minutes pre-time, 15 minutes intra-time and 10 minutes immediate post-service time). Based on this rationale, the RUC requests that CMS accept the RUC recommended values for this service, 1.90 RVUs for 64483.

#### ***CT Thorax***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
71250	Computed tomography, thorax; without contrast material	1.16	1.00

CMS rejected the RUC recommended value to maintain the current value of this service and recommends an interim value of 1.00, the RUC survey low. The RUC would like to provide several comments to address the proposed interim value for this service. First, CMS explains that it has concerns about the validity of survey results since respondents would know the current values for the existing code at the time the survey is being conducted. This assertion is confounding as the RUC compared 71250 to key reference service 71260 *Computed tomography, thorax; with contrast material(s)* (work RVU = 1.24), and noted that the survey respondents indicated that a CT of the thorax without contrast is a less intense service than a CT of the thorax with contrast, as reflected in lower values for almost all of the intensity and complexity measures. If the survey sample was in fact biased based on their previous knowledge of the current work RVUs for 71250, it would be easy to argue that they would rate the service as more intense to perform than the reference code to support a higher value for the surveyed code. Second, it is acknowledged that the value representing the low of any survey could be construed as an outlier, the data representing one survey respondent. CMS should not value services that will be performed by many based on the survey results of one survey respondent. Third, CMS offers no reference codes to support these interim values. **Based on these arguments, the RUC urges CMS to accept the RUC recommendation of 1.16 for 71250.**

#### ***CT Spine***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
72125	Computed tomography, cervical spine; without contrast material	1.16	1.00
72128	Computed tomography, thoracic spine; without contrast material	1.16	1.00
72131	Computed tomography, lumbar spine; without contrast material	1.16	1.00

CMS rejected the RUC recommended values to maintain the current values of these three services and recommends interim values of 1.00, the RUC survey low, for 72125, 72128 and 72131.

#### **72125**

The RUC would like to provide several comments to address the proposed interim value for this service. First, CMS explains that it has concerns about the validity of survey results since respondents would know the current values for the existing code at the time the survey is being conducted. This assertion is confounding as the RUC compared 72125 to key reference service

70498, *Computed tomographic angiography, neck, with contrast material(s), including non-contrast images, if performed, and image post-processing* (work RVU = 1.75), and noted that the survey respondents indicated that a CT of the spine without contrast is a less intense service than a CTA of the neck with contrast, as reflected in lower values for almost all of the intensity and complexity measures. If the survey sample was in fact biased based on their previous knowledge of the current work RVUs for 72125, it would be easy to argue that they would rate the service as more intense to perform than the reference code to support a higher value for the surveyed code. Second, it is acknowledged that the value representing the low of any survey could be construed as an outlier, the data representing one survey respondent. CMS should not value services that will be performed by many based on the survey results of one survey respondent. Third, CMS offers no reference codes to support these interim values.

The RUC agreed that there was sufficient evidence to support the current value of 72125 based on comparisons to the key reference code as well as several other reference points including multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively). **Based on these arguments, the RUC urges CMS to accept the RUC recommended value of 1.16 RVUs for 72125.**

#### 72128

The RUC would like to provide several comments to address the proposed interim value for this service. First, CMS explains that it has concerns about the validity of survey results since respondents would know the current values for the existing code at the time the survey is being conducted. This assertion is confounding as the RUC compared 72128 to key reference service 71260 *Computed tomography, thorax; with contrast material(s)* (work RVU = 1.24), and agreed that these services were similar in physician work despite the fact that the reference code has less total time than the surveyed code, 23 minutes and 25 minutes. This comparison would suggest that the appropriate value for this service should be higher than the current value but the RUC agreed that there was no compelling evidence to increase the value of this service and recommended instead to maintain the current value. Second, it is acknowledged that the value representing the low of any survey could be construed as an outlier, the data representing one survey respondent. CMS should not value services that will be performed by many based on the survey results of one survey respondent. Third, CMS offers no reference codes to support these interim values.

The RUC agreed that there was sufficient evidence to support the current value of 72128 based on comparisons to the key reference code as well as several other reference points including multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively). Based on the specialty's strong survey results, the RUC and the specialty agreed that the survey supported its current value. **Based on these arguments, the RUC urges CMS to accept the RUC recommended value of 1.16 RVUs for 72128.**

#### 72131

The RUC would like to provide several comments to address the proposed interim value for this service. First, CMS explains that it has concerns about the validity of survey results since respondents would know the current values for the existing code at the time the survey is being

conducted. This assertion is confounding as the RUC compared 72131 to key reference service 70498, *Computed tomographic angiography, neck, with contrast material(s), including non-contrast images, if performed, and image post-processing* (work RVU = 1.75), and noted that the survey respondents indicated that a CT of the spine without contrast is a less intense service than a CTA of the neck with contrast, as reflected in lower values for almost all of the intensity and complexity measures. If the survey sample was in fact biased based on their previous knowledge of the current work RVUs for 72131, it would be easy to argue that they would rate the service as more intense to perform than the reference code to support a higher value for the surveyed code. Second, it is acknowledged that the value representing the low of any survey could be construed as an outlier, the data representing one survey respondent. CMS should not value services that will be performed by many based on the survey results of one survey respondent. Third, CMS offers no reference codes to support these interim values.

The RUC agreed that there was sufficient evidence to support the current value of 72131 based on comparisons to the key reference code as well as several other reference points including multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively). Based on the specialty's strong survey results, the RUC and the specialty agreed that the survey supported its current value. **Based on these arguments, the RUC urges CMS to accept the RUC recommended value of 1.16 RVUs for 72131.**

#### ***CT Upper and CT Lower Extremity***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
73200	Computed tomography, upper extremity; without contrast material	1.09	1.00
73700	Computed tomography, lower extremity; without contrast material	1.09	1.00

CMS rejected the RUC recommended values to maintain the current values of these services and recommends interim values of 1.00 RVUs, the RUC survey low, for 73200 and 73700.

The RUC would like to provide several comments to address the proposed interim values for these services. First, CMS explains that it has concerns about the validity of survey results since respondents would know the current values for the existing code at the time the survey is being conducted. This assertion is confounding as the RUC compared 73700 and 73200 to key reference service 73721 *Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material* (work RVU = 1.35), and agreed that these services were similar in physician work despite the fact that the reference code has less total time than the surveyed codes, 25 minutes and 20 minutes. This comparison would suggest that the appropriate values for the surveyed services should be higher than their current value but the RUC agreed that there was no compelling evidence to increase the value of these services and recommended instead to maintain the current values. Second, it is acknowledged that the value representing the low of any survey could be construed as an outlier, the data representing one survey respondent. CMS should not

value services that will be performed by many based on the survey results of one survey respondent. Third, CMS offers no reference codes to support these interim values.

The RUC agreed that there was sufficient evidence to support the current value of 73200 and 73700 based on comparisons to the key reference code as well as several other reference points including multi-specialty points of comparison codes 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, with pre, intra, and post service times of 5, 8, and 5 respectively) and 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, with pre, intra, and post service times of 3, 15, and 5 respectively). Based on the specialty's strong survey results, the RUC and the specialty agreed that the survey supported the current values for both of these services. **Based on these arguments, the RUC urges CMS to accept the RUC recommended value of 1.09 RVUs for 73200 and 1.09 RVUs for 73700.**

***Radiation Treatment Management***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
77427	Radiation treatment management, 5 treatments	3.45	2.92

CMS has rejected the RUC recommended value of 3.45 RVUs and has proposed an interim value of 2.92 which reflects an alteration of the RUC recommended building block of 4-99214 office visit and 2-99213 office visits to 3-99214 and 3-99213 office visits. CMS provides no evidence to support the change in building block and offers no reference codes to support the proposed interim value.

The RUC understands that the specialty society has already expressed a comment for the technical correction that the mathematical calculations in the building block utilized by CMS was incorrect. The mathematically correct value utilizing the CMS proposed building block is 3.37 RVUs not 2.92 RVUs as stated in the Final Rule.

To address the CMS proposal to alter the RUC recommended building block utilized in developing work RVUs for 77427, the RUC offers the following comments. The RUC had a lengthy discussion about how to value this service and its implied 90 day global. With careful oversight from the RUC's Research Subcommittee, the specialties developed a survey instrument to accurately capture the work involved in performing this service. Further, the specialty society provided a detailed description of an entire week of service to all the RUC members during their deliberations. The RUC agreed that the best approach to valuing this service was to utilize a building block. The RUC agreed that the work of 77427 was similar to that of 77315 *Teletherapy, isodose plan (whether hand or computer calculated); complex plus weekly and after treatment planning evaluation and management visits which typically occur over 6 weeks of treatment.* There are six weeks of treatment management that are typically performed and the levels of evaluation and management that occur at this time and post-operatively become higher as the treatment's effects are more apparent to the patient and the physician. Based on this rationale, the RUC agreed that the appropriate building block to be used included 4-99214 visits and 2-99213 visits. The resulting value from utilizing this building block is 3.45 RVUs. The RUC further supported this value with comparisons to 95953 Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours (work RVU = 3.30, XXX Global), 77263 Therapeutic

radiology treatment planning; complex (work RVU = 3.14, XXX Global) and 90962 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face physician visit per month (work RVU = 3.15, XXX Global)

Given the lengthy discussions and deliberations by the RUC as well as comparisons to several reference codes, the RUC agreed that 4- 99214 office visits and 2-99213 office visits should be used in the building block to value this service. Based on this rationale, **the RUC strongly urges CMS to accept the RUC recommended values of 3.45 RVUs for 77427.**

***Esophageal Motility and High Resolution Esophageal Pressure Topography***

CPT code	Descriptor	RUC Rec RVU	CMS Proposed Interim Value
91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; 2-dimensional data	1.50	1.28
91013	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion (eg, stimulant, acid or alkali perfusion)	0.25	0.18

CMS rejected the RUC recommendations for these services as they agreed that they should be subject to budget neutrality. The RUC would like to take this opportunity to address CMS decision to apply budget neutrality to these services. The RUC agreed that there was compelling evidence to change the work relative value associated with these services based on the following information. When first valued during the Harvard studies the physician work for 91010 was valued at 1.65 RVUs, subsequently during the RUC's first Five-Year Review in August 1995, CMS lowered the work value to 1.25 based on the incorrect assumption that an upper gastrointestinal endoscopy would be co-reported with 91010. CMS claims data for 2008 demonstrates that 91010 is reported with 43200 *Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)* (work RVU = 1.59) less than one percent of the time. It was further explained that advancements in technology have had an impact on the physician work. The manometry catheters and recording systems currently available provide more comprehensive data including multiple line tracings representing pressure change verse time at several discrete esophageal loci, which has added time and complexity to the physician's assessment of the data, and the performance of the service. Esophageal manometry is now a much more comprehensive and complex study than it was years ago.

To substantiate the value of 91010, the RUC compared the surveyed service to the Key Reference Service 91122 *Anorectal manometry* (work RVU = 1.77) and agreed that the services are similar in physician work but the reference service entails more overall physician work and time than the surveyed code. The RUC also compared 91010 to 91022 *Duodenal motility (manometric) study* (work RVU = 1.44 and total time= 61 minutes) and agreed that the physician work inherent in the services are analogous and should be valued similarly. Given these reference codes, and the specialty's strong survey results, the RUC recommended the survey 25<sup>th</sup> percentile work RVU of 1.50 for code 91010, placing this service in proper rank order with the reference codes.

To substantiate the value of 91013, the RUC compared the surveyed service to 75565 *Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)* (work RVU = 0.25, 10 minutes intra-service, ZZZ global period) and 96365 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour* (work RVU = 0.21, 9 minutes total time, XXX global period) and determined that these services provide analogous multi-specialty reference points. Finally, the RUC looked at reference code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVU= 0.28, total time= 13 minutes) and agreed that new service 91013 should be valued similarly and further substantiated that the physician work RVU of 0.21 provides proper rank order among and across specialties.

**Based on these arguments, the RUC agrees that budget neutrality should not be applied and urges CMS to accept the RUC recommended value of 1.50 RVUs for 91010 and 0.25 for 91013.**

The RUC would like to take this opportunity to acknowledge the valuable contribution of your staff in attending and observing the RUC Meetings. The RUC agrees that the onsite feedback that CMS representatives provide during the RUC deliberations is invaluable. This important interaction is a primary reason for the high acceptance rate of the RUC recommendations. Based on the number of RUC recommendations that CMS modified, the RUC anticipates that CMS will convene a Refinement Panel next Summer. The RUC appreciates the opportunity to have representation on that Refinement Panel and will provide any RUC related documents that your staff requires to host this meeting.

#### **CMS REQUESTS – POTENTIALLY MISVALUED SERVICES**

##### ***Multi-Specialty Points of Comparison (MPC) List***

In the Medicare Physician Payment Schedule *Proposed Rule* and *Final Rule for 2011 (Table 9)*, CMS indicated that they believe the entire MPC list should be assessed to ensure that services are paid appropriately under the Physician Payment Schedule. CMS prioritized the review of the MPC list to 33 codes, ranking the codes by allowed service units and charges based on CY 2009 claims data.

The RUC notes that 6 of the 33 codes have been identified by another screen and have been re-reviewed by the RUC in the last two years. The RUC Relativity Assessment Workgroup had a robust discussion regarding the MPC list and codes identified by this CMS screen. Although the assumption by the specialty societies, RUC and CMS has been that the MPC list represents services that are stable, well established and understood physician services, the RUC acknowledges the desire to ensure that all services on the MPC are appropriately valued. The MPC Workgroup currently intends to review all criteria for placing a code on the MPC list, review the current MPC list and determine which codes may be appropriate to place on the MPC list.

The RUC agrees that the MPC list is important and requires maintenance to be relevant. However, the RUC requests that CMS allow the RUC to postpone review of the MPC codes identified in the Final Rule until after the MPC Workgroup completes review and revision of the MPC criteria and list. The MPC Workgroup has convened meetings via conference call and plans to meet again at the February 2011 Meeting. **If CMS determines it is acceptable for the Relativity Assessment Workgroup to review MPC codes after the revision of the MPC list, please notify AMA RUC staff prior to our February 3-6, 2011, RUC meeting.** The RUC

understands that CMS requested a review in 2011, but requests that CMS consider a longer-term approach to allow time for the MPC to be reviewed in its entirety.

#### ***Low Value/Billed in Multiple Units***

In the Medicare Physician Payment Schedule *Proposed Rule* and *Final Rule for 2011 (Table 10)*, CMS indicated that they believe services with low work RVUs that are commonly billed with multiple units in a single encounter are an additional appropriate category for identifying potentially misvalued codes. CMS requested that the RUC review 12 services that have high multiple services, one that is commonly performed in multiples of 5 or more per day, with work RVUs of less than or equal to 0.50 RVUs.

In October 2010, the RUC reviewed these 12 services and determined that for 6 codes the RUC assumed number of units when valuing these services are the same or similar to the CMS mean number of units. Secondly, these 6 services were not commonly billed 5 times or more per day (over 50% of the time), therefore, did not meet the CMS criteria screen as indicated (see table below). Lastly, two of these services were recently reviewed by the RUC in April 2010 and submitted to CMS for 2011.

The RUC determined that the 6 remaining services commonly billed 5 times or more per day (over 50% of the time) should be examined. The RUC has requested the specialty societies that perform the remaining low value/billed in multiple unit codes identified, provide an action plan at the February 2011 RUC meeting on how to address these services (Codes 95004, 95010, 95015, 95024, 95027, 95144). The RUC will provide recommendations to CMS for these codes after the RUC has completed its review.

CPT Code	Short descriptor	RUC Assumed Units	CMS Mean # of Units	5 Units	6+ Units	Notes
11101	Biopsy, skin add-on	2	1.5	1%	1%	Does not meet CMS criteria
17003	Destruct premalg les, 2-14	4	4.4	8%	31%	Does not meet CMS criteria
76000	Fluoroscope examination	N/A	1.1	0%	0%	Does not meet CMS criteria
76000	-26		1.0	0%	0%	Does not meet CMS criteria
76000	TC		1.5	0%	0%	Does not meet CMS criteria
*88300	Surgical path, gross -26 TC	1	1.1 1.0 1.1	0% 0% 0%	0% 0% 0%	Does not meet CMS criteria
95004	Percut allergy skin tests	40	50.1	0%	96%	Review Feb 2011
95010	Percut allergy titrate test	7	14.2	6%	61%	Review Feb 2011
95015	Id allergy titrate-drug/bug	rationale=7; intra svc=17	8.3	13%	43%	Review Feb 2011
95024	Id allergy test, drug/bug	12	17.8	2%	77%	Review Feb 2011
95027	Id allergy titrate-airborne	45	39.9	2%	83%	Review Feb 2011
95144	Antigen therapy services	6	6.8	15%	41%	Review Feb 2011
95148	Antigen therapy services	N/A	2.5	7%	9%	Does not meet CMS criteria

CPT Code	Short descriptor	RUC Assumed Units	CMS Mean # of Units	5 Units	6+ Units	Notes
**95904	Sense nerve conduction test -26 TC		4.1 3.7 4.1	4% 6% 3%	27% 20% 29%	Does not meet CMS criteria

\*88300 - April 2010 RUC Review, Top 9 Harvard Screen

\*\*95904 - April 2010 RUC Review, Referred to CPT, Codes Reported Together 75% or More Screen

#### ***Low Value/High Volume Codes***

In the Medicare Physician Payment Schedule *Proposed Rule* and *Final Rule for 2011 (Table 11)*, CMS indicated that they believe services with low work RVUs but high volume based on claims data are another category for identifying potentially misvalued codes. CMS has requested that the RUC review 24 services that have low work RVUs (less than or equal to 0.25) and high utilization.

In October 2010, the RUC questioned the criteria CMS used to identify these services as it appeared some codes may be missing based on the screen criteria indicated. The RUC determined to expand the list to identify codes with a work RVU of 0.50 or below and Medicare utilization of 1 million or more (excluding codes with a 0.00 work RVU). Based on this criteria, 61 codes were identified, 16 of which have already been identified by another Relativity Assessment screen. Additionally, 6 of the 24 codes identified by CMS did not meet the over 1 million utilization criteria and therefore do not appear on this revised list (codes 72040, 73310, 73130, 73620, 92543 and 93701). The RUC will review the 61 codes identified by this expanded screen at the February 2011 RUC meeting.

#### **OCTOBER 2010 RUC RECOMMENDATIONS**

The RUC submits the enclosed recommendations for work relative values and direct practice expense inputs to CMS from the October 2010 RUC Meeting. These recommendations relate to the services identified by the Relativity Assessment Workgroup (RAW), several practice expense refinement recommendations, and several of the Site of Service Anomaly codes identified by CMS for RUC re-review. The new and revised services reviewed at this meeting will be submitted to CMS in May 2011.

In the Comment Letter to the CMS Proposed Rule, the RUC stated that despite our serious concerns with the proposed “reverse building block” methodology, the RUC will take the opportunity to re-review each of the 40 services listed in Tables 15 and 16 of the Proposed Rule at the October 2010 and February 2011 RUC meetings. Additional rationale supporting the outpatient status of these services as well as recommendations for the Site of Service anomaly codes reviewed at the October 2010 RUC Meeting are now being submitted to CMS. We applaud CMS’ decision not to finalize the values for these services prior to RUC review.

Further, CMS has announced in the Final Rule that it will no longer accept the subsequent hospital care codes (99231-99233) as proxies for physician work for 23+ Hour Stay Services with the introduction of the Subsequent Observations Services (99224-99226). Therefore, in the future, the RUC in its recommendations to CMS will utilize the Subsequent Observation Service codes where applicable rather than using the subsequent hospital care codes. Please note that the

Donald Berwick, MD

December 20, 2010

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site-of-service issues submitted at this time do not include any services for which the patient typically remains more than 23 hours in the hospital.

Cost estimates for medical supplies and equipment not listed on the "CMS Labor, Supply and Equipment List for the Year 2010" are based on provided source(s) as noted, such as manufacturer's catalogue prices and may not reflect the wholesale prices, quantity or cash discounts, prices for used equipment or any other factors that may alter the cost estimates. The RUC shares this information with CMS without making specific recommendations on the pricing for supplies and equipment.

Thank you for your careful consideration of the RUC's comments on the proposals for the 2011 Medicare Physician Payment Schedule. We look forward to continued opportunities to offer recommendations to improve the RBRVS.

Sincerely,

A handwritten signature in black ink, appearing to read "Barbara Levy MD".

Barbara S. Levy, MD

cc: RUC Participants

**Table 9 - Codes on the MPC List Referred for RUC Review**

CPT Code	Short descriptor	RUC Review	Global	Work RVU	Pre-Eval	Pre-S/D/W	Pre-Positi	Intra-Service	Post-Svc	Visits	IWPUT	2009 Medicare Utilization	Notes
11056	Trim skin lesions, 2 to 4	Apr-97	000	0.61	2			8	5		0.0567	1,687,654	
11100	Biopsy, skin lesion	Aug-05	000	0.81	5			12	5		0.0488	2,579,687	
11721	Debride nail, 6 or mor	Apr-96	000	0.54	5			8	5		0.0395	7,539,975	
17000	Destruct premalg lesion	Aug-05	010	0.65	4			3	2	99212=1	0.0119	4,730,673	
20610	Drain/inject, joint/burs	Oct-10	000	0.79	5	1	5	5	5		0.10062	5,847,320	Oct 2010, Harvard Over 100,000 screen
31231	Nasal endoscopy, dx	June-93	000	1.10	10			10	10		0.0652	361,190	
31575	Diagnostic laryngoscopy	Sep-05	000	1.10	5	5	5	8	5		0.0904	557,616	
43235	Uppr gi endoscopy, diagnosis	Aug-05	000	2.39	18	5	5	20	15		0.0749	408,630	
43239	Upper GI endoscopy, biopsy	Aug-00	000	2.87	27			34	23.5		0.0511	1,419,531	
45380	Colonoscopy and biopsy	Aug-00	000	4.43	45			51.5	22		0.0569	799,816	
45385	Lesion removal colonoscopy	Jun-93	000	5.3	16			43	15		0.1071	641,691	
52000	Cystoscopy	Aug-05	000	2.23	10	5	2	15	10		0.1131	920,676	
66821	After cataract laser surgery	Aug-05	090	3.42	15			11	10	99213=2	0.0836	566,092	
66984	Cataract surg w/iol, 1 stage	Aug-05	090	10.52	10	10	5	30	10	99212=2 99213=2 99238=0 5	0.2113	1,674,939	April 2008 RUC rec to review in Sept 2011, High IWPUT screen
71020	Chest x-ray	Aug-05	XXX	0.22	1			3	1		0.0584	13,740,080	
71275	Ct angiography, chest	Feb-01	XXX	1.92	9.5			30	10		0.0494	593,556	Feb 2009 RUC rec to review in Sept 2011, CMS Fastest Growing screen
73721	Mri jnt of lwr extre w/o dye	Apr-01	XXX	1.35				20			0.0675	610,825	
74160	Ct abdomen w/dye	Aug-05	XXX	1.27	3			15	5		0.0727	2,219,593	Feb 2008 RUC rec to maintain code reviewed only new codes, Codes Reported Together screen
76700	Us exam, abdom, complete	Aug-05	XXX	0.81	3			10	4		0.0653	1,039,419	
77003	Fluoroguide for spine inject	May-99	XXX	0.60	10			20	5		0.0132	2,185,916	
77290	Set radiation therapy field	Aug-05	XXX	1.56				70			0.0223	339,258	
77300	Radiation therapy dose plan	Aug-05	XXX	0.62				15			0.0413	1,638,636	
77334	Radiation treatment aid(s)	Aug-05	XXX	1.24				35			0.0354	1,476,951	
78815	Pet image w/cl, skull-thigh	Apr-07	XXX	0.00	15			35	15		-0.0192	487,518	
92083	Visual field examination(s)	Aug-05	XXX	0.5	3			10			0.0433	2,580,775	
92250	Eye exam with photos	Aug-05	XXX	0.44				9	5		0.0364	2,175,839	
92980	Insert intracoronary stent	May-94	000	14.82	45			120	60		0.1039	320,072	
93010	Electrocardiogram report	Aug-05	XXX	0.17				4	1		0.0369	19,334,268	
94060	Evaluation of wheezing	Aug-95	XXX	0.31	5			10	5		0.0086	1,231,072	
95165	Antigen therapy services	Feb-06	XXX	0.06				3			0.0200	5,412,909	
95810	Polysomnography, 4 or more	Apr-10	XXX	3.52	15			36.5	15		0.0456	311,495	Apr 2010 RUC recommendation, CMS Fastest Growing
95900	Motor nerve conduction test	Aug-05	XXX	0.42	4			6	4		0.0401	1,371,085	
97110	Therapeutic exercises	Apr-10	XXX	0.45	1			15	2		0.0255	40,440,714	Apr 2010, RUC rec was to maintain, Codes Reported Together 75% or More screen

## RUC Recommendations for Existing Codes - October 2010

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IPUT	CMS Fastest Growing	Codes Reported Together	Harvard Valued - Util Over 100,000	Different Performing SS from Survey	CMS Request PE Review
10060	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	1.50					X		
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	2.45					X		
16020	Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)	0.80						X	
16025	Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)	1.85						X	
20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	0.66					X		
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68					X		
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	0.79					X		
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	Reaffirmed 10.03	X						
23415	Coracoacromial ligament release, with or without acromioplasty	Reaffirmed 9.23	X						

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IPUT	CMS Fastest Growing	Codes Reported Together	Harvard Valued - Util Over 100,000	Different Performing SS from Survey	CMS Request PE Review
25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	Reaffirmed 7.56	X						
27792	Treatment of ankle fracture	Re-review Feb 2011	X						
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus	Re-review Feb 2011	X						
28122	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus	Re-review Feb 2011	X						
28725	Arthrodesis; subtalar	Re-review Feb 2011	X						
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	Re-review Feb 2011	X						
28825	Amputation, toe; interphalangeal joint	Re-review Feb 2011	X						
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release	February 2011 - PE Only				X			
36821	Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)	Re-review Feb 2011	X						
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	Re-review Feb 2011	X						
42415	Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve	Re-review Feb 2011	X						

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IINPUT	CMS Fastest Growing	Codes Reported Together	Harvard Valued - Util Over 100,000	Different Performing SS from Survey	CMS Request PE Review
42420	Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve	Re-review Feb 2011	X						
42440	Excision of submandibular (submaxillary) gland	Reaffirmed 7.13	X						
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	Re-review Feb 2011	X						
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	Re-review Feb 2011	X						
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	Re-review Feb 2011	X						
49652	Lap vent/abd hernia repair	Re-review Feb 2011	X						
49653	Lap vent/abd hern proc comp	Re-review Feb 2011	X						
49654	Lap inc hernia repair	Re-review Feb 2011	X						
49655	Lap inc hern repair comp	Re-review Feb 2011	X						
51736	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	0.17					X		
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	0.17					X		
52341	Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	Reaffirmed 5.35	X						
52342	Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	Reaffirmed 5.85	X						
52343	Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	Reaffirmed 6.55	X						

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IINPUT	CMS Fastest Growing	Codes Reported Together	Harvard Valued - Util Over 100,000	Different Performing SS from Survey	CMS Request PE Review
52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	Reaffirmed 7.05	X						
52345	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	Reaffirmed 7.55	X						
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	Reaffirmed 8.58	X						
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	Reaffirmed 8.69	X						
52500	Transurethral resection of bladder neck (separate procedure)	Reaffirmed 8.14	X						
52640	Relieve bladder contracture	See 4th 5-Yr Rec	X						
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	Reaffirmed 15.39, Survey Feb 2011	X						
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	Reaffirmed 15.18, Survey Feb 2011	X						
54530	Orchiectomy, radical, for tumor; inguinal approach	Reaffirmed 8.46	X						
57287	Revise/remove sling repair	See 4th 5-Yr Rec	X						
61885	Insrt/redo neurostim 1 array	See 4th 5-Yr Rec	X						

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	CMS Fastest Growing	Codes Reported Together	Harvard Valued - Util Over 100,000	Different Performing SS from Survey	CMS Request PE Review
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	Reaffirmed 6.54	X						
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	Reaffirmed 6.05	X						
62355	Removal of previously implanted intrathecal or epidural catheter	Reaffirmed 4.35	X						
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	Reaffirmed 4.33	X						
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump	Reaffirmed 5.65	X						
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming	Reaffirmed 6.10	X						
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	Reaffirmed 4.65	X						
62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming	Review Feb 2011				X		X	

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	CMS Fastest Growing	Codes Reported Together	Harvard Valued - Util Over 100,000	Different Performing SS from Survey	CMS Request PE Review
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	Review Feb 2011				X		X	
63650	Percutaneous implantation of neurostimulator electrode array, epidural	Reaffirmed 7.20	X		X				
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	Reaffirmed 6.05	X		X				
64708	Neuroplasty, major peripheral nerve, arm or leg; other than specified	Reaffirmed 6.36	X						
64831	Suture of digital nerve, hand or foot; 1 nerve	Reaffirmed 9.16	X						
65285	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue	Re-review Feb 2011	X						
67210	Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation	6.36		X					
67220	Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions	6.36		X					
76950	Ultrasonic guidance for placement of radiation therapy fields	New PE Inputs				X			
77011	Computed tomography guidance for stereotactic localization	New PE inputs							X
77014	Computed tomography guidance for placement of radiation therapy fields	New PE inputs							X

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IWPUT	CMS Fastest Growing	Codes Reported Together	Harvard Valued - Util Over 100,000	Different Performing SS from Survey	CMS Request PE Review
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	New PE inputs. Review Sept 2011			X				X
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	New PE inputs. Review Sept 2011			X	X			
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	New PE inputs				X			
88104	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation	0.56					X		
88106	Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation	0.56					X		
88107	Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears and simple filter preparation with interpretation	Deleted from CPT					X		
88108	Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)	0.56					X		
88329	Pathology consultation during surgery;	0.67					X		
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen	1.19					X		
88332	Pathology consultation during surgery; each additional tissue block with frozen section(s)	0.59					X		
92960	Cardioversion, elective, electrical conversion of arrhythmia; external	2.25					X		
95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);	Review Feb 2011				X		X	

CPT Code	Descriptor	RUC Recommendation	Site of Service Screen	High IPUT	CMS Fastest Growing	Codes Reported Together	Harvard Valued - Util Over 100,000	Different Performing SS from Survey	CMS Request PE Review
95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician	Review Feb 2011				X			
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	New PE inputs				X			
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	New PE inputs				X			

October 2010 RUC Meeting Physician Time														
CPT Code	Pre Evaluation Time	Pre-Positioning Time	Dress Scrub and Wait Time	Intra-Service Time	Immediate Post Service Time	99231	99232	99233	99238	99212	99213	Total Time	Origination	
10060	8.0	3.0	5.0	15	10						1	57	CMS Request	
10061	8.0	3.0	5.0	25	10						2	83	CMS Request	
16020	7.0			15	5							27	CMS Request	
16025	10.0	3.0	5.0	20	5							43	CMS Request	
20600	5.0	1.0	5.0	5	5							21	CMS Request	
20605	5.0	1.0	5.0	5	5							21	CMS Request	
20610	5.0	1.0	5.0	5	5							21	CMS Request	
67210	10.0	5.0	2.0	15	5						3	106	CMS Request	
67220	15.0	5.0	3.5	15	10						3	118	CMS Request	
88104				24								24	CMS Request	
88106				16								16	CMS Request	
88108				19								19	CMS Request	
88329				21								21	CMS Request	
88331				25								25	CMS Request	
88332				16								16	CMS Request	
92960	15.0	1.0	5.0	15	15							51	CMS Request	
21025	60.0	10.0	15.0	90	30						2	2	283 Site of Service Anomaly	
23415	40.0	15.0	15.0	60	20							150	Site of Service Anomaly	
25116	40.0	10.0	15.0	60	20						0.5	1	3 249 Site of Service Anomaly	
42440	30.0	10.0	15.0	60	20						0.5	1	1 193 Site of Service Anomaly	
52341	45.0	10.0	15.0	45	20								135 Site of Service Anomaly	
52342	40.0	10.0	10.0	60	20								140 Site of Service Anomaly	
52343	45.0	10.0	10.0	60	25								150 Site of Service Anomaly	
52344	40.0	10.0	10.0	45	20								125 Site of Service Anomaly	
52345	45.0	10.0	15.0	45	20								135 Site of Service Anomaly	
52346	40.0	10.0	10.0	60	20								140 Site of Service Anomaly	
52400	72.5	10.0	15.0	40	25						0.5	1	1 198 Site of Service Anomaly	
52500	45.0	10.0	15.0	45	27.5						0.5		3 231 Site of Service Anomaly	
54530	57.5	10.0	15.0	60	30						0.5	2	1 247 Site of Service Anomaly	
62263	33.0	10.0	5.0	45	20						0.5	1	2 194 Site of Service Anomaly	
62350	33.0	10.0	5.0	60	20						0.5		1 170 Site of Service Anomaly	
62355	33.0	10.0	5.0	30	20						0.5		1 140 Site of Service Anomaly	
62360	33.0	10.0	5.0	60	20						0.5		1 170 Site of Service Anomaly	
62361	33.0	10.0	5.0	60	20						0.5		1 170 Site of Service Anomaly	
62362	33.0	10.0	5.0	60	20						0.5		1 170 Site of Service Anomaly	
62365	33.0	10.0	5.0	45	20						0.5		1 155 Site of Service Anomaly	
63650	33.0	10.0	5.0	60	20						0.5		1 170 Site of Service Anomaly	
63685	33.0	10.0	5.0	60	20						0.5		1 170 Site of Service Anomaly	
64708	35.0	10.0	10.0	60	15						0.5	3	1 220 Site of Service Anomaly	
64831	40.0	10.0	15.0	60	15						0.5	2	2 237 Site of Service Anomaly	

**Summary of Direct Practice Expense Inputs Changes  
RUC Recommendations for CMS Requests - October 2010**

CPT Code	Previous Time Data			Current Recommendation			Change in Practice Expense Components			Change in Clinical Labor Time from Change in Post-Op Visits	
	Clinical Labor Assist	Intra Service Time	99238	99212	99213	Clinical Labor Assist	Intra-Service	99238	99212	99213	
10060	13	15	1			13	15	1			
10061	18	27	0.5	1		17	25	2	-1	-0.5	1
16020	7	10				11	15		4		
16025	13	20				10	15		-3		
20600	5	5				20	20		15		
20605	10	14				4	5		-6		
20610	10	15				3	5		-7		
67210	20	20		2		15	15	3	-5	1	Yes 27
67220	25	25		4		15	15	3	-10	-1	Yes -27
88104	0	21				0	24				
88106	0					0	16				
88108	0					0	19				
88329	10					0	21		-10		
88331	10	23				11	25		1		
88332	2	15				2	16				
92960	23	31				11	15		-12		

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

*Originated from the RUC Relativity Assessment - Harvard Valued – Utilization over 100,000 Screen.*

October 2010

**Incision and Drainage of Abscess**

In October 2009, CPT code 10061 was identified by the RUC Relativity Assessment Workgroup through the Harvard Valued – Utilization over 100,000 screen. The RUC recommended a full RUC survey be conducted. CPT code 10060 was identified as part of the this family to be reviewed.

**10060 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single**

The American College of Surgeons (ACS) and American Podiatric Medical Association (APMA) indicated that code 10060 was originally surveyed in the Harvard studies by emergency medicine physicians who represented less than 1% of all providers of this service in 1991. The HCPAC, in 2005, reviewed the service with survey responses from the predominant provider, podiatrists. However, in 2005, CMS chose to maintain the value for the code, which was based on the original flawed Harvard data and was not supported by any similar reference services. The RUC determined there is compelling evidence to review code 10060 because the current value is still based on flawed Harvard data.

The RUC reviewed the survey results from 45 podiatrists and general surgeons. The RUC is recommending the survey median work RVU of 1.50 for CPT code 10060. The RUC noted that the current median value is the same value that the HCPAC had recommended in 2005. The RUC compared the surveyed code to the key reference code *11402 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm* (work RVU = 1.45 and total time = 56 minutes) and determined that the surveyed service requires approximately the same physician time to perform as the key reference service, 57 and 56 minutes, respectively. Additionally, the survey respondents indicated that the surveyed code requires slightly more mental effort, judgment, technical skill, physical effort and psychological stress to perform than the key reference code. Therefore, the RUC agreed that the survey respondents median value of 1.50 appropriately valued this service slightly higher than the similar key reference service. For additional support the RUC compared code 10060 to MPC services *11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less* (work RVU = 1.03 and total time = 36 minutes) and *11422 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm* (work RVU = 1.68 and total time = 56 minutes) and determined that the survey median relative value appropriately places this service in the proper rank order with these similar services. **The RUC recommends a work RVU of 1.50 for CPT code 10060.**

**10061 Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple**

The RUC reviewed the survey results from 43 podiatrists and general surgeons. Although the survey data for this service suggests a higher value for this service, median survey value of 2.50 work RVUs, the specialties had no compelling evidence to change the current value of the service. The RUC determined that the current work RVU of 2.45 maintains the appropriate value for this service relative to this family and other similar services. To further support maintaining the current value for code 10061, the RUC noted that the key reference code 11423 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU = 2.06 and total time = 76 minutes) required slightly less time than the surveyed code, 76 and 83 minutes, respectively, and the surveyed code was more intense and complex. The RUC also compared the surveyed code to similar MPC code 11424 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm* (work RVU = 2.48 and total time = 86 minutes), both require the similar total time to perform, 83 and 86 minutes, respectively, and are valued similarly, 2.45 and 2.48, respectively. **The RUC recommends a work RVU of 2.45 for CPT code 10061.**

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
10060		Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single	010	1.50
10061		complicated or multiple	010	2.45 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:10060  
 Global Period: 010

Tracking Number

Specialty Society Recommended RVU: 1.50  
 RUC Recommended RVU: 1.50

CPT Descriptor: Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey:

Podiatry: A 68-year-old diabetic female presents with a painful swollen region over her left 5th metatarsal head which developed after wearing new shoes. The region is mildly fluctuant. X-rays demonstrate no fracture or osteomyelitis. A decision is made to perform an incision and drainage.

General Surgery: A 55-year-old diabetic female presents with a painful swollen area over left gluteal area. Examination reveals a fluctuant mass. An incision and drainage is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 22% , In the ASC 0%, In the office 78%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;  
 Discharged the same day 90% , Kept overnight (less than 24 hours) 10% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain procedure to patient/family. Review risks and complications. Obtain consent. Mark operative site. Verify that all required instruments and supplies are available. Assist with appropriate positioning to expose and stabilize operative site (eg, supine, prone, lateral). Drape, and prep site. Local anesthetic is administered. Scrub and gown. Perform "time out."

Description of Intra-Service Work: An incision is made over the abscess site. Purulent drainage is expressed. A culture is obtained. The site is thoroughly irrigated with sterile saline. The cavity is completely opened. Hemostasis is achieved. The wound is packed.

Description of Post-Service Work: Apply appropriate sterile dressing. Write orders for antibiotic and pain medication, as appropriate. Discuss aftercare treatment, including home restrictions (ie, activity, bathing). Dictate operative report and complete medical record documentation. The patient will be examined in the office within a few days and as needed through the 10-day global period to remove the packin/dressing, assess wound healing and abscess resolution, remove

CPT Code: 10060

suture if utilized, and repack wound. Discuss pathology report when available. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2010					
<b>Presenter(s):</b>	Seth Rubenstein, DPM; Timothy Tillo, DPM; Christopher Senkowski, MD FACS; Samuel Smith, MD FACS					
<b>Specialty(s):</b>	podiatry, general surgery					
<b>CPT Code:</b>	10060					
<b>Sample Size:</b>	250	<b>Resp N:</b>	45	<b>Response:</b> 18.0 %		
<b>Sample Type:</b>	Random	<b>Additional Sample Information:</b>				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>		5.00	12.00	30.00	50.00	300.00
<b>Survey RVW:</b>		0.88	1.40	1.50	2.00	2.25
<b>Pre-Service Evaluation Time:</b>				15.00		
<b>Pre-Service Positioning Time:</b>				5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				10.00		
<b>Intra-Service Time:</b>		10.00	10.00	15.00	15.00	25.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00			
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00		
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.00	99239x 0.00			
<b>Office time/visit(s):</b>	<b>16.00</b>	99211x 0.00	12x 1.00	13x 0.00	14x 0.00	15x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	10060	<b>Recommended Physician Work RVU: 1.50</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		8.00	17.00	-9.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		15.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x 0.00	99292x 0.00	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x 0.0	99239x 0.0	
<b>Office time/visit(s):</b>	<b>16.00</b>	99211x 0.00	12x 1.00	13x 0.00
<b>Prolonged Services:</b>	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
			<u>RUC Time</u>
11402	010	1.45	

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

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
			<u>RUC Time</u>	
11420	010	1.03		31,192
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
	010	1.68	<u>RUC Time</u>	46,752

CPT Descriptor 1 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 31.1 %

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 10060	<u>Key Reference CPT Code:</u> 11402	<u>Source of Time</u> RUC Time
Median Pre-Service Time	16.00	10.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	10.00	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	16.0	16.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	57.00	56.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.50	2.43
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.50	2.57
--	------	------

Urgency of medical decision making	2.86	2.50
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.79	2.43
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Physical effort required	2.43	2.29
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.79	2.57
---	------	------

Outcome depends on the skill and judgment of physician	2.93	2.79
--	------	------

Estimated risk of malpractice suit with poor outcome	2.86	2.79
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.50	2.43
----------------------------------	------	------

Intra-Service intensity/complexity	2.57	2.43
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Post-Service intensity/complexity	2.43	2.29
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**Additional Rationale and Comments**

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**

**1. Evidence that incorrect assumptions were made in the previous valuation of the service - a previous survey was conducted by one specialty to obtain a value, but in actuality the service is currently provided primarily by physician from a different specialty.**

During the Harvard study, code 10060 was reviewed by emergency medicine physicians with the vignette "incision and drainage of a 3 cm carbuncle." As shown in the table below, utilization for 10060 in 1991 was less than 1% for the specialty emergency medicine.

SPEC	1991	2008
POD	75%	53%
DERM	6%	11%
FP	5%	12%
GS	4%	6%
GP	3%	1%
IM	3%	6%
EM	0%	4%

**2. Evidence that incorrect assumptions were made in the previous valuation of the service - flawed mechanism or methodology used in the previous valuation**

During the third 5-Year-Review in 2005, CMS requested review of 10060. The APMA conducted a survey and provided compelling evidence that the wrong specialty was surveyed by Harvard. The HCPAC agreed with the specialty society and recommended to adopt the recommended increase in the work RVU; the median work RVU of 1.50. CMS disregarded compelling evidence and maintained the work RVU, which the RUC agreed was based on a flawed methodology. Further, CMS did not base the value on any reference code.

## **Rationale for Recommendation**

### **Why is this code being reviewed?**

CPT code 10061 was identified by the RUC 5YR ID Workgroup through a screen of Harvard-based codes with utilization over 100,000. The APMA requested extraction of the code to resurvey and allow other specialties who perform the service to co-survey. The HCPAC agreed and determined that it would be appropriate for family code 10060 to be surveyed in tandem with 10061. Code 10060 was previously surveyed only by podiatry in 2005 as part of the third 5-Year-Review. The RUC agreed with the HCPAC. CMS requested review of both 10060 and 10061.

### **Compelling evidence**

As discussed in the compelling evidence section on the last page of this summary form, we believe that the original valuation of 10060 was based on a flawed methodology. The wrong specialty was surveyed during the Harvard study, resulting in an incorrect relative work RVU. We also disagree that the vignette used for the survey was typical: "Incision and drainage of a 3 cm carbuncle." Further, in 2005, CMS maintained the value for the code based on a comparison to the flawed Harvard data, without any supporting reference codes. The current survey data and current work RVU result in an IWP/PUT of 0.017, which is significantly less than the intensity for 99211. We believe the intra-work of 10060 is more complex and more intense than 99211.

### **Work RVU Recommendation**

Podiatry and general surgery conducted a RUC survey, using one multispecialty reference list. Although two different typical patient vignettes were utilized in the survey, the median pre-, intra-, and post-times were identical.

We recommend the RUC re-affirm its previous recommendation of 1.50 work RVUs, which is also the survey median work RVU. Because this procedure will typically be performed in an office setting, we are recommending pre- and post-times consistent with this site of service. We note, however, that these times are a minimum, as this procedure is also performed in other sites (outpatient hospital, inpatient hospital) for more labor-intensive patients.

**Pre-time**

Pre-time package 6 (office procedure with anesthesia) is appropriate for code 10060, with the following modifications to the package time:

Evaluation: Subtract 9 minutes (total = 8 min). Information provided by the AMA indicates that an E/M service is performed 45% of the time with 10060. While this is not more than 50%, the consensus panel agrees that nationally, this would be greater than 50%. All of the other evaluation time components are not duplicative with E/M work.

Positioning: Add 2 minutes (total = 3 min) to account for supine positioning. We believe this is a minimum. For many patients, different positioning (eg, prone or lateral) will require more time.

Scrub, dress, wait: No change.

**Comparison to key reference code**

Key reference code 11402 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 1.1 to 2.0 cm compares well with survey code 10060. Both procedures typically involve the same size and depth of skin and subcutaneous tissue. Both procedures are performed under local anesthetic. Both procedures can require varied positioning. Both procedures typically will include one follow-up office visit within the 10-day global period.

Code 11402 was reviewed by the RUC prior to use of pre-time packages. We note that the intra-service description includes what we believe is pre-service work (mark, prep, drape site and administer local). Consequently, it is possible that some of the intra-time shown for 11402 may appropriately belong in pre-time columns. That being said, the total time for day of procedure is the same for both codes.

	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>IM-post</b>	<b>office</b>
<b>11402</b>	1.45	0.025	56	10			25	5	1x99212
<b>10060</b>	1.50	0.034	57	8	3	5	15	10	1x99212

**Comparison to MPC codes**

The recommended value for 10060 compares well with MPC codes 11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less and 11422 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm. Both 11420 and 11422 typically involve skin and subcutaneous tissue. Both procedures are performed under local anesthetic. Both procedures can require varied positioning. Both procedures typically will include one follow-up office visit within the 10-day global period.

	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>IM-post</b>	<b>office</b>
<b>11420</b>	1.03	0.033	36	5			10	5	1x99212
<b>10060</b>	1.50	0.034	57	8	3	5	15	10	1x99212
<b>11422</b>	1.68	0.035	56	10			25	5	1x99212

**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) Medicare data indicate 10060 is typically billed with an E/M service on the day of the procedure.

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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 10060

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each 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 the frequency and percentage for each specialty. Please explain the rationale for this estimate. not available

Specialty	Frequency	Percentage	%
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**Specialty**      **Frequency**      **Percentage**      **%**

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 550,338 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2008 RUC database

Specialty podiatry Frequency 291734 Percentage 53.00 %

Specialty general surgery Frequency 32029 Percentage 5.81 %

Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

CPT Code: 10060

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 10060

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code: 10061  
 Global Period: 010

Tracking Number

Specialty Society Recommended RVU: 2.45  
 RUC Recommended RVU: 2.45

CPT Descriptor: Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple

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**CLINICAL DESCRIPTION OF SERVICE:**

**Vignette Used in Survey:**

**Podiatry:** A 42-year-old male presents 4 days after stepping on a wood splinter on his deck. He states he was able to remove the splinter. He now has pain under the ball of his right foot. Localized swelling and erythema are noted. Examination reveals a fluctuant mass with draining sinuses. X-rays are negative for foreign body. A decision is made to perform an incision and drainage of the abscess.

**General Surgery:** A 53-year-old diabetic male presents with a draining abscess on his anterior thigh for 10 days. Initially, it drained intermittently, but now has grown rapidly in size and is more painful. Examination reveals a fluctuant mass with draining sinuses. Operative drainage is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

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**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 33% , In the ASC 7%, In the office 60%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 50% , Kept overnight (less than 24 hours) 14% , Admitted (more than 24 hours) 36%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 50%

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**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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Description of Pre-Service Work: Explain procedure to patient/family. Review risks and complications. Obtain consent. Mark operative site. Verify that all required instruments and supplies are available. Assist with appropriate positioning to expose and stabilize operative site (eg, supine, prone, lateral). For multiple sites, repositioning may be necessary. Additionally, complicated procedures on an extremity may require a tourniquet. Drape, and prep site. Local anesthetic is administered. Scrub and gown. Perform "time out."

Description of Intra-Service Work: An incision is made over the abscess site. Purulent drainage is expressed. A culture is obtained. The site is digitalized and examined for additional foreign material. The cavity is completely opened and necrotic debris removed. The site is thoroughly irrigated with sterile saline. Hemostasis is achieved. A drain is placed and the wound is packed.

Description of Post-Service Work: Apply appropriate sterile dressing. (Foot procedures will require fitting of a surgical shoe.) Write orders for antibiotic and pain medication, as appropriate. Discuss aftercare treatment, including home restrictions (ie, activity, bathing). Dictate operative report and complete medical record documentation. The patient will be examined in the office within a few days and as needed through the 10-day global period to remove the packing/dressing, assess wound healing and abscess resolution, remove sutures and drain, and repack/redress wound. Discuss pathology report and culture results when available. Discuss progress with PCP (verbal and written). Dictate progress notes for medical record.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2010				
<b>Presenter(s):</b>	Seth Rubenstein, DPM; Timothy Tillo, DPM; Christopher Senkowski, MD FACS; Samuel Smith, MD FACS				
<b>Specialty(s):</b>	podiatry, general surgery				
<b>CPT Code:</b>	10061				
<b>Sample Size:</b> 250	<b>Resp N:</b> 43	<b>Response:</b> 17.2 %			
<b>Sample Type:</b> Random	<b>Additional Sample Information:</b>				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Service Performance Rate</b>		2.00	6.00	<b>12.00</b>	40.00
<b>Survey RVW:</b>		1.10	2.00	<b>2.50</b>	3.20
<b>Pre-Service Evaluation Time:</b>				<b>20.00</b>	
<b>Pre-Service Positioning Time:</b>				<b>5.00</b>	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>10.00</b>	
<b>Intra-Service Time:</b>		15.00	20.00	<b>25.00</b>	29.00
<b>Immediate Post Service-Time:</b>	<b>10.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b>	99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>	
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.00</b>	99239x <b>0.00</b>		
<b>Office time/visit(s):</b>	<b>32.00</b>	99211x <b>0.00</b>	12x <b>2.00</b>	13x <b>0.00</b>	14x <b>0.00</b>
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b> 10061		<b>Recommended Physician Work RVU: 2.45</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		8.00	17.00	-9.00
<b>Pre-Service Positioning Time:</b>		3.00	1.00	2.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		25.00		
<b>Immediate Post Service-Time:</b>	<b>10.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b>	99292x <b>0.00</b>	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>
<b>Discharge Day Mgmt:</b>	<b>0.00</b>	99238x <b>0.0</b>	99239x <b>0.0</b>	
<b>Office time/visit(s):</b>	<b>32.00</b>	99211x <b>0.00</b>	12x <b>2.00</b>	13x <b>0.00</b>
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

's this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11423	010	2.06	RUC Time

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

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
11423	010	2.06	RUC Time	18,878
<u>CPT Descriptor 1</u> Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
11424	010	2.48	RUC Time	6,488

CPT Descriptor 2 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 23.2 %

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>10061</u>	<u>Key Reference CPT Code:</u> <u>11423</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	16.00	20.00	
Median Intra-Service Time	25.00	30.00	
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	32.0	16.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	83.00	76.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

3.10

2.90

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

3.10

3.00

Urgency of medical decision making

3.80

2.80

**Technical Skill/Physical Effort (Mean)**

Technical skill required

3.20

2.80

Physical effort required

3.00

2.60

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

3.70

2.90

Outcome depends on the skill and judgment of physician

3.50

3.30

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

3.00

2.80

Intra-Service intensity/complexity

3.10

2.90

Post-Service intensity/complexity

2.80

2.80

**Additional Rationale and Comments**

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

**Why is this code being reviewed?**

CPT code 10061 was identified by the RUC 5YR ID Workgroup through a screen of Harvard-based codes with utilization over 100,000. The APMA requested extraction of the code to resurvey and allow other specialties who perform the service to co-survey. The HCPAC agreed and determined that it would be appropriate for family code 10060 to be surveyed in tandem with 10061. Code 10060 was previously surveyed only by podiatry in 2005 as part of the third 5-Year-Review. The RUC agreed with the HCPAC. CMS requested review of both 10060 and 10061.

**Background**

During the Harvard study, code 10061 was reviewed by general surgeons with the vignette "incision and drainage of an abscess, complicated/multiple." As shown in the table below, general surgery utilization for 10061 in 1991 was only 8%. In 1991, podiatry was the typical Medicare provider. Although, in 2008 podiatry is the dominant provider, it is clear that they are not the "only" provider. This is not surprising given the wide variability of the CPT descriptor (carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia).

SPEC	1991	2008
POD	69%	45%
DERM	9%	11%
GS	8%	12%
FP	4%	6%
GP	2%	1%
IM	2%	3%

**Work RVU Recommendation**

Podiatry and general surgery conducted a RUC survey, using one multispecialty reference list. Two different typical patient vignettes were utilized. Median pre-time for both specialties was the same. The median survey intra-time for general surgery was 5 minutes greater than for podiatry. Both specialties indicated two follow-up office visits within the 10-day global period.

The survey median work RVU of 2.50 is just minimally greater than the current work RVU. Therefore, we recommend maintaining the current work RVU of 2.45. Because the majority of providers of 10061 will typically perform this service in an office setting, we are recommending pre- and post-times consistent with an office site of service. We note, however, that these times are a minimum, as this procedure is also performed in other sites (outpatient hospital, inpatient hospital) for more labor-intensive patients. We are also recommending two post-op office visits. The current work RVU and the recommended times and visits result in an IPUT of 0.039, which is slightly greater than 10060 and maintains appropriate rank order.

**Pre-time**

Pre-time package 6 (office procedure with anesthesia) is appropriate for code 10061, with the following modifications to the package time:

Evaluation: Subtract 9 minutes (total = 8 min). Information provided by the AMA indicates that an E/M service is performed 51% of the time with 10061. All of the other evaluation time components are not duplicative with E/M work.

Positioning: Add 2 minutes (total = 3 min) to account for supine positioning. We believe this is a minimum. For many patients, different positioning (eg, prone or lateral) or re-positioning (for multiple) will require more time.

Scrub, dress, wait: No change.

**Comparison to key reference code**

Key reference code 11423 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm compares well with survey code 10061. Both procedures typically involve the same size and depth of skin and subcutaneous tissue. Both procedures are performed under local anesthetic. Both procedures can require varied positioning. The key difference is that 10061 will typically require two

post-op office visits to monitor resolution of the infection. The additional incremental work RVU of 0.39 reasonably accounts for this difference.

	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>IM-post</b>	<b>office</b>
<b>11423</b>	2.06	0.033	76	10	5	5	30	10	1x 99212
<b>10061</b>	2.45	0.039	83	8	3	5	25	10	2x 99212

#### **Comparison to MPC codes**

The recommended value for 10061 compares well with MPC codes 11423 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* and 11424 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 3.1 to 4.0 cm*. Both 11422 and 11424 typically involve skin and subcutaneous tissue. Both procedures are performed under local anesthetic. One key difference is that 10061 will typically require two post-op office visits to monitor resolution of the infection. The additional incremental work RVU of 0.39 reasonably accounts for this difference compared with 11423. With respect to 11424, the additional procedure time is offset by the additional post-op visit work.

	<b>RVW</b>	<b>IWPUT</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>IM-post</b>	<b>office</b>
<b>11423</b>	2.06	0.033	76	10	5	5	30	10	1x 99212
<b>10061</b>	2.45	0.039	83	8	3	5	25	10	2x 99212
<b>11424</b>	2.48	0.035	86	10	5	5	40	10	1x 99212

#### **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) Medicare data indicate 10061 is typically billed with an E/M service on the day of the procedure.

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.

#### **FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 10061

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each 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 the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty                      Frequency                      Percentage                      %

**Specialty**                    **Frequency**                    **Percentage**            **%**

**Specialty**                    **Frequency**                    **Percentage**            **%**

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 179,756 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2008 RUC database

Specialty podiatry Frequency 80189 Percentage 44.60 %

**Specialty general surgery** Frequency 20941 Percentage 11.64 %

**Specialty**      **Frequency**      **Percentage**      **%**

Do many physicians perform this service across the United States? Yes

## **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 10061

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
*Originated from the RUC Relativity Assessment - Different Performing Specialty from Survey Screen*

October 2010

**Dressings/Debridement of Partial-Thickness Burns**

In October 2009, the RUC Relativity Assessment Workgroup identified CPT codes 16020 and 16025 through the Different Performing Specialty from Survey screen. In 2005, these codes were surveyed and presented by the American Burn Association and the American Society of Plastic Surgeons. According to current Medicare claims data, the dominant providers are family medicine, emergency medicine, internal medicine and general surgery.

***16020 Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)***

The American Academy of Family Physicians (AAFP) conducted a survey and recommended to maintain the current work RVU of 0.80 for CPT code 16020. The RUC agreed that the current value for code 16020, with 15 minutes intra-service time, is supported by the key reference service 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* (work RVU = 0.81 and intra-service time = 12 minutes) which requires similar physician work, time, intensity and complexity to perform. The RUC recommends maintaining the current work RVU of 0.80 for CPT code 16020, as it maintains the appropriate value in relation to this family of services and similar services. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 0.80 for CPT code 16020.**

***16025 Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)***

The American Academy of Family Physicians (AAFP) conducted a survey and recommend to maintain the current work RVU of 1.85 for CPT code 16025. The RUC agreed that the current value for code 16025, with 20 minutes intra-service time, is supported by the key reference service 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and intra-service time = 15 minutes) which requires similar physician work, time, intensity and complexity to perform. CPT code 16025 requires 5 more minutes of intra-service time compared to the key reference code, however, the survey respondents indicated and the RUC agreed that the intra-service for 16025 is more intense and complex. The RUC recommends maintaining the current work RVU of 1.85 for CPT code 16025, as it maintains the appropriate value in relation to this family of services and similar services. Based on these comparisons and that the specialty did not provide compelling evidence to change the current value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.85 for CPT code 16025.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
16020		Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)	000	0.80 (No Change)
16025		medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)	000	1.85 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:16020  
 Global Period: 000

Tracking Number

Specialty Society Recommended RVU: **0.80**  
 RUC Recommended RVU: **0.80**

CPT Descriptor: Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 25-year-old firefighter suffered partial-thickness burns of the forehead and right dorsal hand from an open flame. The burns involved 4% of the body surface area. He underwent debridement of nonviable, blistered skin and application of a wound dressing. Anesthesia was not required.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 7%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 7%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service work includes an appropriate history and physical exam; 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 risks and benefits and to obtain informed consent. Other pre-service work includes the administration of antibiotics; dressing, scrubbing, and waiting to begin the procedure; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary instruments and supplies are present and available.

Description of Intra-Service Work: The burn wound is debrided of blisters and non-adherent devitalized tissue. The extent of the debridement is small and involves less than 5% of the total body surface area. The wound is then dressed with a gauze dressing.

Description of Post-Service Work: Post-service work begins after the application of the wound dressing and includes monitoring the patient's stability; writing orders; and communicating with the family and other health care professionals (including written and oral reports and orders). Post-service work also includes the physician's final examination of the patient, instructions for continuing care of the procedure sites, and preparation of all records.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2010				
<b>Presenter(s):</b>	Thomas Weida, M.D.				
<b>Specialty(s):</b>	Family Medicine				
<b>CPT Code:</b>	16020				
<b>Sample Size:</b>	136	<b>Resp N:</b>	29	<b>Response:</b> 21.3 %	
<b>Sample Type:</b>	Panel	<b>Additional Sample Information:</b> All physicians currently serving on the AAFP Board of Directors and commissions			
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Service Performance Rate</b>		0.00	0.00	3.00	5.00
<b>Survey RVW:</b>		0.73	0.99	1.40	1.90
<b>Pre-Service Evaluation Time:</b>				10.00	
<b>Pre-Service Positioning Time:</b>				2.00	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				3.00	
<b>Intra-Service Time:</b>		5.00	10.00	15.00	15.00
<b>Immediate Post Service-Time:</b>		<u>5.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

<b>CPT Code:</b>	16020	<b>Recommended Physician Work RVU: 0.80</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
Pre-Service Evaluation Time:		7.00	7.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		15.00		
<b>Immediate Post Service-Time:</b>	<u>5.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
11100	000	0.81	RUC Time

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

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
11100	000	0.81	RUC Time	2,455,457
<u>CPT Descriptor 1</u> Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
20610	000	0.79	CMS Time File	5,625,121

CPT Descriptor 2 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 20.6 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>16020</u>	<u>Key Reference CPT Code:</u> <u>11100</u>	<u>Source of Time</u> RUC Time
Median Pre-Service Time	7.00	5.00	
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	0.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	27.00	22.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

2.36

2.68

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

2.21

2.64

Urgency of medical decision making

3.07

2.93

**Technical Skill/Physical Effort (Mean)**

Technical skill required

3.29

3.39

Physical effort required

2.96

2.86

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

3.11

3.14

Outcome depends on the skill and judgment of physician

3.11

3.43

Estimated risk of malpractice suit with poor outcome

3.11

3.25

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

2.18

2.14

Intra-Service intensity/complexity

3.14

3.29

Post-Service intensity/complexity

2.43

2.46

**Additional Rationale and Comments**

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 identified by the Five-Year Review Identification Workgroup through the “Different Performing Specialty from Survey” screen. This code was surveyed and presented to the RUC in 2005 by the American Burn Association (ABA) and the American Society of Plastic Surgeons (ASPS). The dominant specialties, according to Medicare claims data, are now family medicine (25%), emergency medicine (16%), internal medicine (12%), and general surgery (12%). The current work value of 0.80 represents the recommendations of the ABA and ASPS and the RUC in 2005.

Although respondents to this survey rated the work of 16020 higher than the current 0.80 assigned to the code, we did not identify any compelling evidence that would support an increase in the work value of this code. Accordingly, we are recommending that the RUC maintain the current value of 0.80.

We believe that the current value of 0.80 is supported by a comparison with the key reference service, 11100, which is another integumentary procedure code with a 000-day global period. Code 11100 has a current value of 0.81 work RVUs. Respondents rated code 16020 as having 3 minutes more intra-service time and 5 minutes more total time than code 11100 but generally rated the intensity/complexity of code 16020 slightly less than that of code 11100. We believe that the greater time and generally lower intensity/complexity of code 16020 relative to 11100 suggest that the two codes should be an approximately equal amount of work. Thus, we believe that the current value of code 16020 at 0.80 is correct, given that code 11100 is currently valued at 0.81.

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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: 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) This code is typically reported on the same date as an E/M service, such as an office visit or emergency department visit.

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.	CPT Code	Global	Work RVUs	Pre-Service	Intra-Service	Post-Service	Total Time
4.	16020	000	0.80	7	15	5	27
5.	99213-25	XXX	0.97	3	15	5	23
6.	Totals		1.77	10	30	10	50

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## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 16020

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty                    How often?

Specialty                    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 68000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. N/A

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

16,927 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. N/A

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 16020

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:16025  
 Global Period: 000

Tracking Number

Specialty Society Recommended RVU: **1.85**  
 RUC Recommended RVU: **1.85**

CPT Descriptor: Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 46-year-old man suffered flame burns as the result of a house fire. He has partial-thickness burns of the face and both hands involving 8% of the body surface area. He underwent debridement of nonviable, blistered skin and application of a wound dressing. Anesthesia was not required.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

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**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

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**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 12%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 4%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service work includes an appropriate history and physical exam; 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 risks and benefits and to obtain informed consent. Other pre-service work includes the administration of antibiotics; dressing, scrubbing, and waiting to begin the procedure; supervising the positioning, prepping, and draping of the patient; and ensuring that the necessary instruments and supplies are present and available.

Description of Intra-Service Work: The burn wound is debrided of blisters and non-adherent devitalized tissue. The debridement involves 10% of the total body surface area. The wound is then dressed with a gauze dressing.

Description of Post-Service Work: Post-service work begins after the application of the wound dressing and includes monitoring the patient's stability; writing orders; and communicating with the family and other health care professionals (including written and oral reports and orders). Post-service work also includes the physician's final examination of the patient, instructions for continuing care of the procedure sites, and preparation of all records.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Thomas Weida, M.D.				
Specialty(s):	Family Medicine				
CPT Code:	16025				
Sample Size:	136	Resp N:	27	Response: 19.8 %	
Sample Type:	Panel	Additional Sample Information: All physicians currently serving on the AAFP Board of Directors and commissions			
	Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate	0.00	0.00	0.00	2.00	30.00
Survey RVW:	0.80	1.65	2.01	3.08	5.50
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			3.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	5.00	15.00	20.00	30.00	60.00
Immediate Post Service-Time:	5.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	16025	Recommended Physician Work RVU: 1.85		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		10.00	7.00	3.00
Pre-Service Positioning Time:		3.00	0.00	3.00
Pre-Service Scrub, Dress, Wait Time:		5.00	0.00	5.00
Intra-Service Time:		20.00		
Immediate Post Service-Time:	5.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
54150	000	1.90	RUC Time

CPT Descriptor Circumcision, using clamp or other device with regional dorsal penile or ring block

**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.

			Most Recent	
<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
54150	000	1.90	RUC Time	136
<u>CPT Descriptor 1</u> Circumcision, using clamp or other device with regional dorsal penile or ring block				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent</u>
29445	000	1.78	RUC Time	Medicare Utilization 13,152

CPT Descriptor 2 Application of rigid total contact leg cast

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>16025</u>	<u>Key Reference CPT Code:</u> <u>54150</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	18.00	25.00	
Median Intra-Service Time	20.00	15.00	
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	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>43.00</b>	<b>45.00</b>	
Other time if appropriate			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	2.81	2.93
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.38	2.63
--	------	------

Urgency of medical decision making	3.40	3.07
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.58	3.56
--------------------------	------	------

Physical effort required	3.27	3.07
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.46	3.22
---	------	------

Outcome depends on the skill and judgment of physician	3.46	3.48
--	------	------

Estimated risk of malpractice suit with poor outcome	3.46	3.41
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code**    **Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.58	2.67
----------------------------------	------	------

Intra-Service intensity/complexity	3.62	3.48
------------------------------------	------	------

Post-Service intensity/complexity	2.85	2.63
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**Additional Rationale and Comments**

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

This code was identified by the Five-Year Review Identification Workgroup through the "Different Performing Specialty from Survey" screen. This code was surveyed and presented to the RUC in 2005 by the American Burn Association (ABA) and the American Society of Plastic Surgeons (ASPS). The dominant specialties, according to Medicare claims

data, are now family medicine (24%), general surgery (19%), plastic surgery (17%), and internal medicine (13%). The current work value of 1.85 represents the recommendations of the ABA and ASPS and the RUC in 2005.

Although respondents to this survey rated the work of 16025 higher than the current 1.85 assigned to the code, we did not identify any compelling evidence that would support an increase in the work value of this code. Accordingly, we are recommending that the RUC maintain the current value of 1.85.

We believe that the current value of 1.85 is supported by a comparison to the key reference service, code 54150. Both codes have approximately the same total time, and respondents rated code 16025 as having 5 minutes more intra-service time. Additionally, respondents rated code 16025 higher than 54150 on 6 out of 11 intensity/complexity measures, including intra-service intensity. Thus, the current value of 1.85 for code 16025 appears to be correct in relation to code 54150, which is currently valued at 1.90.

Regarding the pre-service time for code 16025, the most relevant pre-service time package includes only 7 minutes for pre-service evaluation and no time for either positioning of the patient or scrubbing, etc. In this case, we felt the survey median pre-service time estimates were more appropriate and are recommending them instead of the pre-service package time. The added time for positioning reflects the fact that burns of this size typically involves more than one site on the patient's body, which necessitates re-positioning the patient. We believe the more extensive nature of this procedure (up to 10% total body surface area) also supports time for scrubbing, dressing, etc.

Finally, we note that the median service performance rate among survey respondents was zero (0). This is not surprising given the relatively low incidence of this service and the fact that family physicians provide only about 25% of the total volume. In keeping with RUC procedure in this instance, we have attached a spreadsheet that summarizes the data for those who indicated that they perform the procedure, for those that indicated they don't, and the aggregate data.

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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: 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) This code is typically reported on the same date as an E/M service, such as an office visit or emergency department visit.

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.

	CPT Code	Global	Work RVUs	Pre-Service	Intra-Service	Post-Service	Total Time
5.	16025	000	1.85	18	20	5	43
6.	99213-25	XXX	0.97	3	15	5	23
7.	Totals		2.82	21	35	10	66

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## FREQUENCY INFORMATION

CPT Code: 16025

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 16025

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

**Specialty Family Medicine**      How often? Sometimes

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 10612

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. N/A

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 2,653  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. N/A

**Specialty**                    **Frequency**                    **Percentage**                    **%**

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

## **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 16025

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

	Response Number	Percentage of Survey Respondents who found Vignette to be Typical	Median Service Performance Rate	Median Survey RVW:	Median Pre-Service Evaluation Time:	Median Pre-Service Positioning Time:	Median Pre-Service Scrub, Dress, Wait Time:	Median Intra-Service Time:	Median Immediate Post Service-Time:	Key CPT Code
Service Performance Rate = 0	16	94%	0	2.5	10	3	5	20	10	54150 (5 responses)
Service Performance Rate Greater Than 0	11	100%	3	1.63	5	2	3	15	5	12052 (3 responses)
Aggregate	27	96%	0	2.01	3	3	5	20	5	54150 (7 responses)

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

*Originated from the RUC Relativity Assessment - Harvard Valued – Utilization over 100,000 Screen*

October 2010

**Arthrocentesis**

In October 2009, the RUC identified CPT code 20605 as potentially misvalued through the Harvard Valued-Utilization over 100,000 screen. In February 2010, the specialties submitted an action plan to the RUC's Relativity Assessment Workgroup which included the entire Arthrocentesis family of services, CPT codes 20600, 20605 and 20610. The RUC recommended that these services be RUC surveyed.

**20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)**

The RUC reviewed the survey results from 76 orthopaedic surgeons, hand surgeons, podiatrists and rheumatologists for CPT code 20600. The RUC noted that although this service is typically reported with an Evaluation and Management service on the same day, 11 minutes of pre-service time is necessary because the physician is discussing possible complications and obtaining consent, prepping the joint for the injection and waiting for the local anesthesia to take effect.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work value of 0.66 for this service. To justify this value, the RUC compared the surveyed code to key reference CPT code 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU= 0.75 and intra time= 5 minutes). The RUC agreed that these services should be valued similarly given that they have similar physician work and analogous total time, 21 minutes and 20 minutes, respectively. In addition, the RUC compared CPT code 20600 to MPC code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions* (work RVU= 0.61 and total time= 15 minutes). The RUC agreed that the surveyed code should be valued higher due to greater total time than the reference code, 21 minutes and 15 minutes, respectively. **The RUC recommends a work RVU of 0.66 for CPT code 20600.**

**20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)**

The RUC reviewed the survey results from 72 orthopaedic surgeons, hand surgeons, podiatrists and rheumatologists for CPT code 20605. The RUC noted that although this service is typically reported with an Evaluation and Management service on the same day, 11 minutes of pre-service time is necessary because the physician is discussing possible complications and obtaining consent, prepping the joint for the injection and waiting for the local anesthesia to take effect.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work value of 0.68 for this service. To justify this value, the RUC compared the surveyed code to MPC code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions* (work RVU= 0.61 and total time= 15 minutes). The RUC agreed that the surveyed code should be valued higher due to greater total time than the reference code, 21 minutes and 15 minutes, respectively. Additionally, the RUC compared CPT code 20605 to reference CPT code 20612 *Aspiration and/or injection of ganglion cyst(s) any location* (work RVU= 0.70 and total time= 20 minutes). The RUC agreed that these two analogous services should be valued closely as they have identical intra-service time, 5 minutes, and similar total time, 21 minutes and 20 minutes, respectively. **The RUC recommends a work RVU of 0.68 for CPT code 20605.**

**20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)**

The RUC reviewed the survey results from 61 orthopaedic surgeons, hand surgeons, podiatrists and rheumatologists for CPT code 20610. The RUC noted that although this service is typically reported with an Evaluation and Management service on the same day, 11 minutes of pre-service time is necessary because the physician is discussing possible complications and obtaining consent, prepping the joint for the injection and waiting for the local anesthesia to take effect.

The RUC analyzed the survey's estimated physician work and agreed that these data support maintaining the current work value of 0.79 for this service. To further justify this value, the RUC compared the surveyed code to MPC code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions* (work RVU= 0.61 and total time= 15 minutes). The RUC agreed that the surveyed code should be valued higher due to greater total time than the reference code, 21 minutes and 15 minutes, respectively. In addition, the RUC compared CPT code 20610 to MPC code 31575 *Laryngoscopy, flexible fiberoptic; diagnostic* (work RVU= 1.10 and intra time= 8 minutes). The RUC noted that the reference code has more total time, 28 minutes, and intra-service time, 8 minutes compared to 5 minutes for the surveyed code. Given this, the RUC agreed that the reference code should be valued higher. **The RUC recommends a work RVU of 0.79 for CPT code 20610.**

The RUC also reviewed a table of other injection codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes. This review using magnitude estimation comparison of work RVUs further supports the relative ranking and current work RVUs for 20600, 20605, and 20610.

SOURCE	CPT	DESCRIPTOR	RVW	TOT MIN	EVAL	POSIT	SDW	INTRA	POST
2002	<b>51702</b>	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	0.50	8				8	
1996 MPC	<b>11721</b>	Debridement of nail(s) by any method(s); 6 or more	0.54	18	5			8	5
2002	<b>20552</b>	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.66	14	5			5	4
	<b>20600</b>	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	0.66	21	5	1	5	5	5

SOURCE	CPT	DESCRIPTOR	RVW	TOT MIN	EVAL	POSIT	SDW	INTRA	POST
	<b>20605</b>	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	21	5	1	5	5	5
2002	<b>20612</b>	Aspiration and/or injection of ganglion cyst(s) any location	0.70	20	10			5	5
1995 MPC	<b>65205</b>	Removal of foreign body, external eye; conjunctival superficial	0.71	15	5			5	5
2002	<b>20550</b>	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.75	20	10			5	5
2002 MPC	<b>20551</b>	Injection(s); single tendon origin/insertion	0.75	20	10			5	5
2008	<b>64455</b>	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	0.75	20	10			5	5
2002	<b>20553</b>	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)	0.75	22	7			10	5
	<b>20610</b>	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	0.79	21	5	1	5	5	5
1993	<b>11950</b>	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	0.84	35	10			15	10
2002	<b>20526</b>	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	0.94	16	6			5	5
2005 MPC	<b>31575</b>	Laryngoscopy, flexible fiberoptic; diagnostic	1.10	28	5	5	5	8	5
2005	<b>67515</b>	Injection of medication or other substance into Tenon's capsule	1.40	21	6	5		5	5
2005	<b>67500</b>	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	1.44	25	5	5	5	5	5
2002	<b>64445</b>	Injection, anesthetic agent; sciatic nerve, single	1.48	32	8			16	8
2008 MPC	<b>64449</b>	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	1.81	60	19	5	5	20	11

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
20600		Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	000	0.66 (No Change)
20605		intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	000	0.68 (No Change)
20610		major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)  (If imaging guidance is performed, see 76942, 77002, 77012, 77021)	000	0.79 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:20600  
 Global Period: 000

Tracking Number

Specialty Society Recommended RVU: **0.66**  
 RUC Recommended 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: A 50-year old patient presents with inflammation of a small joint (eg, metacarpophalangeal, metatarsophalangeal) and is treated by aspiration of the joint, followed by injection of a steroid.

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

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain procedure to patient/family. Discuss possible complications and obtain consent. Verify that all required instruments and supplies are available. The patient is positioned appropriately for injection access to the joint. Injection site is marked and confirmed. The site is prepped.

Description of Intra-Service Work: MCP Intra-Service Work: The metacarpophalangeal joint is palpated. Local anesthetic is infiltrated at the injection site. The needle for aspiration/injection is inserted into the joint just beneath the extensor mechanism and dorsal to the collateral ligament. The injection of medication is performed slowly, but with consistent pressure. The joint distention is noted. The needle is removed.

MTP Intra-Service Work: The metatarsophalangeal joint is palpated. Local anesthetic is infiltrated at the injection site. The needle for aspiration/injection is inserted into the joint just beneath the extensor mechanism and dorsal to the collateral ligament. The injection of medication is performed slowly, but with consistent pressure. The joint distention is noted. The needle is removed.

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. To ascertain whether the pharmaceuticals have been delivered to the appropriate location, the joint or area is put through passive range of motion. The patient is instructed to avoid strenuous activity involving the injected region for at least 48 hours. Patients should be cautioned that they might experience

CPT Code: 20600

worsening symptoms during the first 24 to 48 hours, related to a possible steroid flare, which can be treated with ice and NSAIDs. Dictate procedure for medical record, copy PCP and insurance.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	William Creevy, MD; Tye Ouzounian, MD; Daniel Nagle, MD; Seth Rubenstein, DPM; Timothy Tillo, DPM; Eileen Moynihan, MD				
Specialty(s):	Orthopaedic Surgery; Hand Surgery; Podiatry; Rheumatology				
CPT Code:	20600				
Sample Size:	737	Resp N:	76	Response: 10.3 %	
Sample Type:	Random	Additional Sample Information:			
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>
Service Performance Rate		2.00	15.00	50.00	100.00
Survey RVW:		0.40	0.75	1.00	1.21
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				3.00	
Pre-Service Scrub, Dress, Wait Time:				3.00	
Intra-Service Time:		1.00	3.00	5.00	5.00
Immediate Post Service-Time:	<u>5.00</u>				
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	20600	Recommended Physician Work RVU: 0.66		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	17.00	-12.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		5.00		
Immediate Post Service-Time:	<u>5.00</u>			
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20550	000	0.75	RUC Time

CPT Descriptor Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
			RUC Time	Most Recent
11056	000	0.61		1,586,212

CPT Descriptor 1 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
			RUC Time	Most Recent
20551	000	0.75		201,332

CPT Descriptor 2 Injection(s); single tendon origin/insertion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20526	000	0.94	RUC Time

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: 12      % of respondents: 15.7 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code: 20600</u>	<u>Key Reference CPT Code: 20550</u>	<u>Source of Time</u>
			RUC Time
Median Pre-Service Time	11.00	10.00	
Median Intra-Service Time	5.00	5.00	
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	
Prolonged Services Time	0.0	0.00	
Median Total Time	21.00	20.00	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	2.50	2.42
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.33	2.33
--	------	------

Urgency of medical decision making	2.08	2.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.25	2.83
--------------------------	------	------

Physical effort required	2.17	2.08
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.33	2.17
---	------	------

Outcome depends on the skill and judgment of physician	3.42	3.17
--	------	------

Estimated risk of malpractice suit with poor outcome	2.17	2.00
--	------	------

INTENSITY/COMPLEXITY MEASURESCPT CodeReference Service 1Time Segments (Mean)

Pre-Service intensity/complexity	2.25	2.17
----------------------------------	------	------

Intra-Service intensity/complexity	2.83	2.67
------------------------------------	------	------

Post-Service intensity/complexity	2.00	2.08
-----------------------------------	------	------

**Additional Rationale and Comments**

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.

**Why is this code being reviewed?**

Code 20600 was also identified by the RUC 5-Year-Review ID Workgroup through the "Harvard-Valued - Utilization Over 100,000" screen.

## **Background**

For CPT 2002 and 2003, the CPT Editorial Panel replaced CPT code 20550 *Injection, tendon sheath, ligament, trigger points or ganglion cyst* with an entire new family of codes that differentiates the various levels of physician work involved in providing these injections. In May 2001, the RUC submitted a recommendation to CMS that these services should all be valued at the existing value of 20550 (work RVU = 0.86) until all specialties involved in providing these services had the opportunity to survey this family of services to determine the differentiation in physician work. CMS accepted this recommendation and retained the value of 0.86 for these services, pending further review by the RUC.

In April 2002, the RUC received recommendations from a consensus group of specialties, including: neurology, orthopaedic surgery, physiatry, rheumatology, podiatry, anesthesiology, plastic surgery, hand surgery, and spine surgery. For all codes, other than the highest level 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal tunnel*, the consensus panel of specialties recommended work relative values below the interim value of 0.86. The RUC agreed that CPT 20550 had been overvalued in the past, but determined that the values presented by the specialty societies remained higher than the actual work performed for these services.

The RUC extensively reviewed the new/revised codes, with an average intra-time of 5 minutes, in comparison to other physician services with low intra-service time. The RUC compared these injection codes to other services with similar intra-service times, including: 67515 *Injection of medication or other substance into Tenon's capsule* (work RVU = 0.61; intra = 6 min); 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU = 1.32, intra = 12 min); 65205 *Removal of foreign body, external eye; conjunctival superficial* (work RVU = 0.71, intra = 5 min); and 11950 *Subcutaneous injection of filling material (eg, collagen); 1 cc or less* (work RVU = 0.83, intra = 15 min).

After considering these cross-specialty comparisons, the RUC agreed that code 20552 *Injection; single or multiple trigger point(s), one or two muscles* should be valued the same as 20600 *Arthrocentesis, aspiration and/or injection, small joint, bursa or ganglion cyst (eg, fingers or toes)* (work RVU = 0.66). The RUC then valued 20526, 20550, and 20551 utilizing the same relativity as the survey medians for these codes. The RUC agreed that CPT code 20553 has the same work as 20550 and 20551. CPT code 20612 was deemed to be more work than 20600 and 20605 and was therefore valued at 0.70. The RUC agrees that these recommendations reflect the appropriate rank-order and relativity in this family of services.

Additionally, the **RUC recommends 20600 *Arthrocentesis, aspiration and/or injection; small joint or bursa or ganglion cyst (eg, fingers, toes)* (work RVU = 0.66) and 20605 *Arthrocentesis, aspiration and/or injection; intermediate joint or bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)* (work RVU = 0.68) should be remained unchanged from 2002**, as these CPT revisions are editorial in nature and **the relative values are appropriate within this family of services**.

Further, during the third 5-year-review, codes 20600 and 20610 were surveyed. Because there was no compelling evidence presented, the RUC did not accept the specialty recommendation to increase the work RVU. Instead, the RUC recommended maintaining the current value and not accepting the new survey times.

## **Work RVU Recommendation**

Code 20600 was co-surveyed by orthopaedic surgery, orthopaedic foot and ankle surgery, podiatry, hand surgery, and rheumatology. The same reference service list and same vignettes were used by all specialties. Although the survey median work RVU suggests a higher value for the code, **the consensus panel representing all involved specialties recommend maintaining the current work RVU of 0.66 and accepting the survey times**. We note the recommended work RVU is less than our survey 25% work RVU of 0.75. This recommendation is based on the discussion presented above that indicates in 2002 the work RVU for 20600 was considered by the RUC to be appropriately valued (by magnitude estimation) compared to a much larger set of similar procedures within the family and across specialties.

## **Pre-time**

Pre-time package 6 (office procedure with anesthesia) is selected, with the following modifications to the package time. **Evaluation:** Subtract 12 minutes to account for work performed during an E/M visit. We note that only 50-60% of the time an E/M will be billed in conjunction with 20600. Medicare and other payors have LCDs that preclude billing an E/M on the same day as a minor procedure for established patients. Therefore, for 40-50% of the national population, the 12 minutes will never be paid.

Positioning: No change.  
Scrub, dress, wait: No change.

**Comparison to key reference code**

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>20550</b>	0.75	20	10			5	5
<b>20600</b>	0.66	21	5	1	5	5	5

**Comparison to MPC codes**

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>11056</b>	0.61	15	2			8	5
<b>20600</b>	0.66	21	5	1	5	5	5
<b>20551</b>	0.75	22	10			5	5

**Comparison to other codes with 000-global**

SOURCE	CPT	DESCRIPTOR	RVW	TOT MIN	EVAL	POSIT	SDW	INTRA	POST
2002	<b>51702</b>	Insertion of temporary indwelling bladder catheter, simple (eg, Foley)	0.50	8				8	
1996 MPC	<b>11721</b>	Debridement of nail(s) by any method(s); 6 or more	0.54	18	5			8	5
2002	<b>20552</b>	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.66	14	5			5	4
	<b>20600</b>	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	0.66	21	5	1	5	5	5
	<b>20605</b>	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	21	5	1	5	5	5
2002	<b>20612</b>	Aspiration and/or injection of ganglion cyst(s) any location	0.70	20	10			5	5
1995 MPC	<b>65205</b>	Removal of foreign body, external eye; conjunctival superficial	0.71	15	5			5	5
2002	<b>20550</b>	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.75	20	10			5	5
2002 MPC	<b>20551</b>	Injection(s); single tendon origin/insertion	0.75	20	10			5	5
2008	<b>64455</b>	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	0.75	20	10			5	5
2002	<b>20553</b>	Injection(s), single or multiple trigger point(s), 3 or more muscle(s)	0.75	22	7			10	5
	<b>20610</b>	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	0.79	21	5	1	5	5	5
1993	<b>11950</b>	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	0.84	35	10			15	10
2002	<b>20526</b>	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	0.94	16	6			5	5
2005 MPC	<b>31575</b>	Laryngoscopy, flexible fiberoptic, diagnostic	1.10	28	5	5	5	8	5
2005	<b>67515</b>	Injection of medication or other substance into Tenon's capsule	1.40	21	6	5		5	5
2005	<b>67500</b>	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	1.44	25	5	5	5	5	5
2002	<b>64445</b>	Injection, anesthetic agent; sciatic nerve, single	1.48	32	8			16	8
2008 MPC	<b>64449</b>	Injection, anesthetic agent, lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	1.81	60	19	5	5	20	11

## **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. According to CMS data provided by the RUC, 20600 is typically performed with an E/M on the same day

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20600

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 384,556 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty Please explain the rationale for this estimate. 2008 RUC database utilization

Specialty podiatry Frequency 168000 Percentage 43.68 %

Specialty orthopaedic surgery Frequency 87900 Percentage 22.85 %

Specialty rheumatology

Frequency 51300

Percentage 13.34 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 20600

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:20605  
 Global Period: 000

Tracking Number

Specialty Society Recommended RVU: **0.68**  
 RUC Recommended RVU: **0.68**

CPT Descriptor: Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 50-year old patients presents with inflammation of an intermediate joint (eg, wrist, ankle) and is treated by aspiration of the joint, followed by injection of a steroid.

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

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain procedure to patient/family. Discuss possible complications and obtain consent.

Verify that all required instruments and supplies are available. The patient is positioned appropriately for injection access to the joint. Injection site is marked and confirmed. The site is prepped.

Description of Intra-Service Work: Intra-work – Wrist. The radiocarpal joint is located just distal to Lister's tubercle. Local anesthetic is infiltrated at the injection site. The needle for aspiration/injection is inserted into the joint proximal to the scapholunate ligaments and just distal to the radial articular surface. The injection of medication is performed slowly, but with consistent pressure. The joint distention is noted. The needle is removed.

Intra-work - Ankle. The ankle joint is palpated. Local anesthetic is infiltrated at the injection site. The needle for aspiration/injection is inserted into the anterior aspect of the joint, lateral to the common extensor tendon. The injection of medication is performed slowly, but with consistent pressure. The joint distention is noted. The needle is removed.

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. To ascertain whether the pharmaceuticals have been delivered to the appropriate location, the joint or area is put through passive range of motion. The patient is instructed to avoid strenuous activity involving the injected region for at least 48 hours. Patients should be cautioned that they might experience

CPT Code: 20605

worsening symptoms during the first 24 to 48 hours, related to a possible steroid flare, which can be treated with ice and NSAIDs. Dictate procedure for medical record, copy PCP and insurance.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010					
Presenter(s):	William Creevy, MD; Tye Ouzounian, MD; Daniel Nagle, MD; Seth Rubenstein, DPM; Timothy Tillo, DPM; Eileen Moynihan MD					
Specialty(s):	Orthopaedic Surgery; Hand Surgery; Podiatry; Rheumatology					
CPT Code:	20605					
Sample Size:	737	Resp N:	72	Response: 9.7 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		5.00	24.00	53.00	150.00	600.00
Survey RVW:		0.40	0.82	1.00	1.30	1.90
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				3.00		
Pre-Service Scrub, Dress, Wait Time:				3.00		
Intra-Service Time:		1.00	3.00	5.00	5.00	12.00
Immediate Post Service-Time:	5.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00			
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	20605	Recommended Physician Work RVU: 0.68		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	17.00	-12.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		5.00		
Immediate Post Service-Time:	5.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20526	000	0.94	RUC Time

CPT Descriptor Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
11056	000	0.61	RUC Time	1,586,212
<u>CPT Descriptor 1</u> Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
20551	000	0.75	RUC Time	201,332

CPT Descriptor 2 Injection(s); single tendon origin/insertion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20612	000	0.70	RUC Time

CPT Descriptor Aspiration and/or injection of ganglion cyst(s) any location

**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: 29.1 %**

<b>TIME ESTIMATES (Median)</b>	<b>CPT Code: 20605</b>	<b>Key Reference CPT Code: 20526</b>	<b>Source of Time RUC Time</b>
Median Pre-Service Time	11.00	6.00	
Median Intra-Service Time	5.00	5.00	
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	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>21.00</b>	<b>16.00</b>	
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.05	2.70
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.95
--	------	------

Urgency of medical decision making	2.48	2.25
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.19	3.20
--------------------------	------	------

Physical effort required	2.24	2.20
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.24	2.40
---	------	------

Outcome depends on the skill and judgment of physician	3.33	3.30
--	------	------

Estimated risk of malpractice suit with poor outcome	2.14	2.45
--	------	------

INTENSITY/COMPLEXITY MEASURESCPT CodeReference Service 1Time Segments (Mean)

Pre-Service intensity/complexity	2.57	2.60
----------------------------------	------	------

Intra-Service intensity/complexity	2.95	3.00
------------------------------------	------	------

Post-Service intensity/complexity	2.25	2.00
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**Additional Rationale and Comments**

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

**Why is this code being reviewed?**

Code 20605 was also identified by the RUC 5-Year-Review ID Workgroup through the "Harvard-Valued - Utilization Over 100,000" screen.

**Background**

For CPT 2002 and 2003, the CPT Editorial Panel replaced CPT code 20550 Injection, tendon sheath, ligament, trigger points or ganglion cyst with an entire new family of codes that differentiates the various levels of physician work involved in providing these injections. In May 2001, the RUC submitted a recommendation to CMS that these services should all be valued at the existing value of 20550 (work RVU = 0.86) until all specialties involved in providing these services had the opportunity to survey this family of services to determine the differentiation in physician work. CMS accepted this recommendation and retained the value of 0.86 for these services, pending further review by the RUC.

In April 2002, the RUC received recommendations from a consensus group of specialties, including: neurology, orthopaedic surgery, physiatry, rheumatology, podiatry, anesthesiology, plastic surgery, hand surgery, and spine surgery. For all codes, other than the highest level 20526 Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal tunnel, the consensus panel of specialties recommended work relative values below the interim value of 0.86. The RUC agreed that CPT 20550 had been overvalued in the past, but determined that the values presented by the specialty societies remained higher than the actual work performed for these services.

The RUC extensively reviewed the new/revised codes, with an average intra-time of 5 minutes, in comparison to other physician services with low intra-service time. The RUC compared these injection codes to other services with similar intra-service times, including: 67515 Injection of medication or other substance into Tenon's capsule (work RVU = 0.61; intra = 6 min); 64405 Injection, anesthetic agent; greater occipital nerve (work RVU = 1.32, intra = 12 min); 65205 Removal of foreign body, external eye; conjunctival superficial (work RVU = 0.71, intra = 5 min); and 11950 Subcutaneous injection of filling material (eg, collagen); 1 cc or less (work RVU = 0.83, intra = 15 min).

After considering these cross-specialty comparisons, the RUC agreed that code 20552 Injection; single or multiple trigger point(s), one or two muscles should be valued the same as 20600 Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers or toes) (work RVU = 0.66). The RUC then valued 20526, 20550, and 20551 utilizing the same relativity as the survey medians for these codes. The RUC agreed that CPT code 20553 has the same work as 20550 and 20551. CPT code 20612 was deemed to be more work than 20600 and 20605 and was therefore valued at 0.70. The RUC agrees that these recommendations reflect the appropriate rank-order and relativity in this family of services.

Additionally, the **RUC recommends 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa or ganglion cyst (eg, fingers, toes) (work RVU = 0.66) and 20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) (work RVU = 0.68) should be remained unchanged from 2002**, as these CPT revisions are editorial in nature and the relative values are appropriate within this family of services.

**Work RVU Recommendation**

Code 20605 was co-surveyed by orthopaedic surgery, orthopaedic foot and ankle surgery, podiatry, hand surgery, and rheumatology. The same reference service list and same vignettes were used by all specialties. Although the survey median work RVU suggests a higher value for the code, the consensus panel representing all involved specialties recommend maintaining the current work RVU of 0.68 and accepting the survey times. The recommended value of 0.68 is well below our survey 25% work RVU of 0.82. This recommendation is based on the discussion presented above that indicates in 2002 the work RVU for 20605 was considered by the RUC to be appropriately valued (by magnitude estimation) compared to a much larger set of similar procedures within the family and across specialties..

**Pre-time**

Pre-time package 6 (office procedure with anesthesia) is selected, with the following modifications to the package time:

Evaluation: Subtract 12 minutes to account for work performed during an E/M visit. We note that only 50-60% of the time an E/M will be billed in conjunction with 20605. Medicare and other payors have LCDs that preclude billing an E/M on the same day as a minor procedure for established patients. Therefore, for 40-50% of the national population, the 12 minutes will never be paid.

Positioning: No change.

Scrub, dress, wait: No change.

Comparison to key reference code

	<b>RVW</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>IM-post</b>
<b>20550</b>	0.75	20	10			5	5
<b>20605</b>	0.68	21	5	1	5	5	5

Comparison to MPC codes

	<b>RVW</b>	<b>Total Time</b>	<b>Eval</b>	<b>Posit</b>	<b>SDW</b>	<b>INTRA</b>	<b>IM-post</b>
<b>11056</b>	0.61	15	2			8	5
<b>20605</b>	0.68	21	5	1	5	5	5
<b>20551</b>	0.75	22	10			5	5

Comparison to other codes with 000-global

<b>SOURCE</b>	<b>CPT</b>	<b>DESCRIPTOR</b>	<b>RVW</b>	<b>TOT MIN</b>	<b>EVAL</b>	<b>POSIT</b>	<b>SDW</b>	<b>INTRA</b>	<b>POST</b>
2002	<b>51702</b>	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	0.50	8				8	
1996 MPC	<b>11721</b>	Debridement of nail(s) by any method(s), 6 or more	0.54	18	5			8	5
2002	<b>20552</b>	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.66	14	5			5	4
	<b>20600</b>	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	0.66	21	5	1	5	5	5
	<b>20605</b>	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	21	5	1	5	5	5
2002	<b>20612</b>	Aspiration and/or injection of ganglion cyst(s) any location	0.70	20	10			5	5
1995 MPC	<b>65205</b>	Removal of foreign body, external eye, conjunctival superficial	0.71	15	5			5	5
2002	<b>20550</b>	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.75	20	10			5	5
2002 MPC	<b>20551</b>	Injection(s); single tendon origin/insertion	0.75	20	10			5	5
2008	<b>64455</b>	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	0.75	20	10			5	5
2002	<b>20553</b>	Injection(s), single or multiple trigger point(s), 3 or more muscle(s)	0.75	22	7			10	5
	<b>20610</b>	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	0.79	21	5	1	5	5	5
1993	<b>11950</b>	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	0.84	35	10			15	10
2002	<b>20526</b>	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	0.94	16	6			5	5
2005 MPC	<b>31575</b>	Laryngoscopy, flexible fiberoptic; diagnostic	1.10	28	5	5	5	8	5
2005	<b>67515</b>	Injection of medication or other substance into Tenon's capsule	1.40	21	6	5		5	5
2005	<b>67500</b>	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	1.44	25	5	5	5	5	5
2002	<b>64445</b>	Injection, anesthetic agent; sciatic nerve, single	1.48	32	8			16	8
2008 MPC	<b>64449</b>	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	1.81	60	19	5	5	20	11

## 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. According to CMS data provided by the RUC, 20605 is typically performed with an E/M on the same day

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20605

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

**Specialty Podiatry**      How often? Commonly

**Specialty Rheumatology**      How often? Commonly

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 the frequency and percentage for each specialty. Please explain the rationale for this estimate. not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 483,106 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2008 RUC database utilization

**Specialty orthopaedic surgery**      **Frequency 139800**      **Percentage 28.93 %**

CPT Code: 20605

Specialty podiatry      Frequency 131900      Percentage 27.30 %

Specialty rheumatology      Frequency 60010      Percentage 12.42 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 20605

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code: 20610  
 Global Period: 000

Tracking Number

Specialty Society Recommended RVU: **0.79**  
 RUC Recommended 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 50-year old patient presents with inflammation of a major joint (eg, shoulder, hip, knee) and is treated by aspiration of the joint, followed by injection of a steroid.

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

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;  
 Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain procedure to patient/family. Discuss possible complications and obtain consent.

Verify that all required instruments and supplies are available. The patient is positioned appropriately for injection access to the joint. Injection site is marked and confirmed. The site is prepped.

Description of Intra-Service Work: Intra-Work - Shoulder. The glenohumeral joint can be injected from an anterior, posterior, or superior approach.. Anterior Approach - The needle is placed just medial to the head of the humerus and 1 cm lateral to the coracoid process. The needle is directed posteriorly and slightly superiorly and laterally. If the needle hits against bone, it should be pulled back and redirected at a slightly different angle. Posterior Approach - The needle is inserted 2 to 3 cm inferior to the posterolateral corner of the acromion and directed anteriorly in the direction of the coracoid process. The injection of medication is performed slowly, but with consistent pressure. The needle is removed.

Intra-Work - Subacromial. The distal, lateral, and posterior edges of the acromion are palpated. A needle is inserted just inferior to the posterolateral edge of the acromion and directed toward the opposite nipple. The injection of medication is performed slowly, but with consistent pressure. The needle is removed.

Intra-Work – Knee. The needle is inserted into the suprapatellar pouch, from the lateral aspect above the patella. The needle is directed medial. The injection of medication is performed slowly, but with consistent pressure. The needle is removed

Intra-Work-- Thigh. The needle is inserted through the lateral approach superior to the greater trochanter. Synovial fluid is aspirated to confirm the location of the needle prior to injection. The injection of medication is performed slowly, but with consistent pressure. The needle is removed.

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. To ascertain whether the pharmaceuticals have been delivered to the appropriate location, the joint or area is put through passive range of motion. The patient is instructed to avoid strenuous activity involving the injected region for at least 48 hours. Patients should be cautioned that they might experience worsening symptoms during the first 24 to 48 hours, related to a possible steroid flare, which can be treated with ice and NSAIDs. Dictate procedure for medical record, copy PCP and insurance.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	William Creevy, MD; Tye Ouzounian, MD; Daniel Nagle, MD; Seth Rubenstein, DPM; Timothy Tillo, DPM; Eileen Moynihan MD				
Specialty(s):	Orthopaedic Surgery; Hand Surgery; Podiatry; Rheumatology				
CPT Code:	20610				
Sample Size:	737	Resp N:	61	Response: 8.2 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		2.00	23.00	100.00	300.00
Survey RVW:		0.50	0.90	1.00	1.40
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				3.00	
Pre-Service Scrub, Dress, Wait Time:				3.00	
Intra-Service Time:		1.00	3.00	5.00	7.00
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x	0.00	99292x	0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x	0.00	99232x	0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x	0.00	99239x	0.00
Office time/visit(s):	<u>0.00</u>	99211x	0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x	0.00	55x 0.00	56x 0.00
57x 0.00					

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	20610	Recommended Physician Work RVU: 0.79			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		5.00	17.00	-12.00	
Pre-Service Positioning Time:		1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00	
Intra-Service Time:		5.00			
Immediate Post Service-Time:	<u>5.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x	0.00	99292x	0.00
Other Hospital time/visit(s):	<u>0.00</u>	99231x	0.00	99232x	0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x	0.0	99239x	0.0
Office time/visit(s):	<u>0.00</u>	99211x	0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x	0.00	55x 0.00	56x 0.00
		57x 0.00			

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20526	000	0.94	RUC Time

CPT Descriptor Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")e

**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.

				Most Recent
<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
11056	000	0.61	RUC Time	1,586,212
<u>CPT Descriptor 1</u> Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
31575	000	1.10	RUC Time	542,548

CPT Descriptor 2 Laryngoscopy, flexible fiberoptic; diagnostic

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
10021	000	1.27	RUC Time

CPT Descriptor Fine needle aspiration; without imaging guidance

**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: 26.2 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>20610</u>	<u>Key Reference CPT Code:</u> <u>20526</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	11.00	6.00	
Median Intra-Service Time	5.00	5.00	
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	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>21.00</b>	<b>16.00</b>	
<b>Other time if appropriate</b>			

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered	3.33	3.07
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	2.87
--	------	------

Urgency of medical decision making	2.60	2.33
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.47	3.20
--------------------------	------	------

Physical effort required	2.07	2.07
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.60	2.60
---	------	------

Outcome depends on the skill and judgment of physician	3.33	3.33
--	------	------

Estimated risk of malpractice suit with poor outcome	2.20	2.20
--	------	------

INTENSITY/COMPLEXITY MEASURESCPT CodeReference Service 1Time Segments (Mean)

Pre-Service intensity/complexity	3.07	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.13	2.73
------------------------------------	------	------

Post-Service intensity/complexity	2.27	2.27
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**Additional Rationale and Comments**

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

**Why is this code being reviewed?**

Code 20610 was identified by the RUC 5-Year-Review ID Workgroup through the "Harvard-Valued - Utilization Over 100,000" screen.

## Background

For CPT 2002 and 2003, the CPT Editorial Panel replaced CPT code 20550 Injection, tendon sheath, ligament, trigger points or ganglion cyst with an entire new family of codes that differentiates the various levels of physician work involved in providing these injections. In May 2001, the RUC submitted a recommendation to CMS that these services should all be valued at the existing value of 20550 (work RVU = 0.86) until all specialties involved in providing these services had the opportunity to survey this family of services to determine the differentiation in physician work. CMS accepted this recommendation and retained the value of 0.86 for these services, pending further review by the RUC.

In April 2002, the RUC received recommendations from a consensus group of specialties, including: neurology, orthopaedic surgery, physiatry, rheumatology, podiatry, anesthesiology, plastic surgery, hand surgery, and spine surgery. For all codes, other than the highest level 20526 Injection, therapeutic (eg, local anesthetic, corticosteroid); carpal tunnel, the consensus panel of specialties recommended work relative values below the interim value of 0.86. The RUC agreed that CPT 20550 had been overvalued in the past, but determined that the values presented by the specialty societies remained higher than the actual work performed for these services.

The RUC extensively reviewed the new/revised codes, with an average intra-time of 5 minutes, in comparison to other physician services with low intra-service time. The RUC compared these injection codes to other services with similar intra-service times, including: 67515 Injection of medication or other substance into Tenon's capsule (work RVU = 0.61; intra = 6 min); 64405 Injection, anesthetic agent; greater occipital nerve (work RVU = 1.32, intra = 12 min); 65205 Removal of foreign body, external eye; conjunctival superficial (work RVU = 0.71, intra = 5 min); and 11950 Subcutaneous injection of filling material (eg, collagen); 1 cc or less (work RVU = 0.83, intra = 15 min).

After considering these cross-specialty comparisons, the RUC agreed that code 20552 Injection; single or multiple trigger point(s), one or two muscles should be valued the same as 20600 Arthrocentesis, aspiration and/or injection, small joint, bursa or ganglion cyst (eg, fingers or toes) (work RVU = 0.66). The RUC then valued 20526, 20550, and 20551 utilizing the same relativity as the survey medians for these codes. The RUC agreed that CPT code 20553 has the same work as 20550 and 20551. CPT code 20612 was deemed to be more work than 20600 and 20605 and was therefore valued at 0.70. The RUC agrees that these recommendations reflect the appropriate rank-order and relativity in this family of services.

Additionally, the RUC recommends 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa or ganglion cyst (eg, fingers, toes) (work RVU = 0.66) and 20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) (work RVU = 0.68) should be remained unchanged from 2002, as these CPT revisions are editorial in nature and the relative values are appropriate within this family of services.

Further, during the third 5-year-review, codes 20600 and **20610** were surveyed. Because there was no compelling evidence presented, the RUC did not accept the specialty recommendation to increase the work RVU. Instead, the **RUC recommended maintaining the current value** and not accepting the new survey times.

## Work RVU Recommendation

Code 20610 was co-surveyed by orthopaedic surgery, orthopaedic foot and ankle surgery, podiatry, hand surgery, and rheumatology. The same reference service list and same vignettes were used by all specialties. Although the survey median work RVU suggests a higher value for the code, the consensus panel representing all involved specialties recommend maintaining the current work RVU of 0.79 and accepting the survey times. We note the work RVU of 0.79 is below our survey 25% work RVU. This recommendation is based on the discussion presented above for family codes 20600 and 20605. This recommendation also reflects the multi-specialty consensus panel's magnitude estimation of the work of 20610 compared with many other similar codes.

## Pre-time

Pre-time package 6 (office procedure with anesthesia) is selected, with the following modifications to the package time:

- Evaluation: Subtract 12 minutes to account for work performed during an E/M visit. We note that only 50-60% of the time an E/M will be billed in conjunction with 20610. Medicare and other payors have LCDs that preclude billing an E/M on the same day as a minor procedure for established patients. Therefore, for 40-50% of the national population, the 12 minutes will never be paid.
- Positioning: No change.

Scrub, dress, wait: No change.

### **Comparison to key reference code**

Key reference code 20526 was reviewed prior to development of pre-time packages. Code 20526 and 20610 will require the same time, however, 20526 is more intense/complex due to the possibility of median nerve injury if the insertion comes into contact with the closely located median nerve. Similarly, compared to the other two arthrocentesis codes (20600, 20605), 20610 is the more intense/complex due to the possibility of the insertion coming into contact with the closely located femoral nerve. A nerve injury would be a very serious complication that physicians strive very intensely to avoid.

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>20526</b>	0.94	16	6			5	5
<b>20610</b>	0.79	21	5	1	5	5	5

### **Comparison to MPC codes**

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post
<b>11056</b>	0.61	15	2			8	5
<b>20610</b>	0.79	21	5	1	5	5	5
<b>31575</b>	1.10	28	5	5	5	8	5

### **Comparison to other codes with 000-global**

SOURCE	CPT	descriptor	RVW	TOT MIN	EVAL	POSIT	SDW	INTRA	POST
2002	<b>51702</b>	Insertion of temporary indwelling bladder catheter; simple (eg, Foley)	0.50	8				8	
1996 MPC	<b>11721</b>	Debridement of nail(s) by any method(s); 6 or more	0.54	18	5			8	5
2002	<b>20552</b>	Injection(s), single or multiple trigger point(s), 1 or 2 muscle(s)	0.66	14	5			5	4
	<b>20600</b>	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	0.66	21	5	1	5	5	5
	<b>20605</b>	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	0.68	21	5	1	5	5	5
2002	<b>20612</b>	Aspiration and/or injection of ganglion cyst(s) any location	0.70	20	10			5	5
1995 MPC	<b>65205</b>	Removal of foreign body, external eye, conjunctival superficial	0.71	15	5			5	5
2002	<b>20550</b>	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.75	20	10			5	5
2002 MPC	<b>20551</b>	Injection(s), single tendon origin/insertion	0.75	20	10			5	5
2008	<b>64455</b>	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, MortonÆs neuroma)	0.75	20	10			5	5
2002	<b>20553</b>	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)	0.75	22	7			10	5
	<b>20610</b>	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	0.79	21	5	1	5	5	5
1993	<b>11950</b>	Subcutaneous injection of filling material (eg, collagen), 1 cc or less	0.84	35	10			15	10
2002	<b>20526</b>	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	0.94	16	6			5	5
2005 MPC	<b>31575</b>	Laryngoscopy, flexible fiberoptic; diagnostic	1.10	28	5	5	5	8	5
2005	<b>67515</b>	Injection of medication or other substance into Tenon's capsule	1.40	21	6	5		5	5
2005	<b>67500</b>	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	1.44	25	5	5	5	5	5
2002	<b>64445</b>	Injection, anesthetic agent; sciatic nerve, single	1.48	32	8			16	8
2008 MPC	<b>64449</b>	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including	1.81	60	19	5	5	20	11

SOURCE	CPT	descriptor	RVW	TOT MIN	EVAL	POSIT	SDW	INTRA	POST
		catheter placement)							

## **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. According to CMS data provided by the RUC, 20610 is typically performed with an E/M on the same day

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 20610

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,625,121 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2008 RUC database utilization

Specialty orthopaedic surgery      Frequency 3193800      Percentage 56.77 %

Specialty rheumatology      Frequency 665000      Percentage 11.82 %

Specialty      Frequency 0      Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 20610

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

*Originated from the RUC Relativity Assessment - Harvard Valued - Utilization over 30,000 and Codes Reported 75% or More Together Screen*

October 2010

**Shoulder Arthroscopy- Practice Expense Only**

In February 2010, the following services were identified through CMS' screen for Harvard valued services with utilization over 30,000 and Codes Reported 75% or More Together Screen as being frequently billed together;

- 29824 *Arthroscopy, shoulder, surgical; distal claviclelectomy including distal articular surface (Mumford procedure)*(Work RVU = 8.98, 090 day global)
- 29826 *Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release* (Work RVU = 8.98, 090 day global)
- 29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair* (Work RVU = 15.59, 090 day global)
- 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* (Work RVU = 13.16, 090 day global)

The Workgroup recommended that the RUC consider that 29826 is reported as a stand alone procedure less than 1% of the time per Medicare claims data. CPT code 29826 was placed on the RUC's October 2010 agenda for review of its practice expense inputs, specifically regarding the post operative 090 day global period, as they may be considered duplicative when billed together. The specialty noted that 29826 should not be converted to a ZZZ global period as the service, in the non-Medicare population, is typically performed as a stand alone procedure.

In October 2010, when the RUC attempted to review this issue regarding possible duplication in practice expense inputs, the specialty did not provide a presenter for the meeting. **The RUC agreed that this issue should be postponed to the February 2011 meeting.**

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release  (For open procedure, use 23130 or 23415)	090	Direct Practice Expense Inputs, Postponed until February 2011

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
*Originated through the Harvard Valued - Utilization over 100,000 Screen*

October 2010

**Uroflowmetry – Practice Expense Only**

In February 2010, CPT codes 51736 *Simple uroflowmetry (UFR)* (eg, stop-watch flow rate, mechanical uroflowmeter) and 51741 *Complex uroflowmetry* (eg, calibrated electronic equipment) were identified by the RUC's Relativity Assessment Workgroup through its Harvard Valued Utilization over 100,000 Screen, and the RUC recommended a review of the physician work required to perform these services. After a review of the physician work in April 2010, the RUC recommended a review of the direct practice expense inputs for 51736 and 51741, due to the apparent change in technology.

In October 2010, the RUC carefully reviewed the specialty recommended reduced typical clinical labor, medial supplies, and equipment for codes 51736 and 51741. The RUC made minor edits and agreed with the modified specialty recommendations. The RUC also noted that the clinical labor time was reduced by over 75% for each of the services. **The RUC recommends the attached direct practice expense inputs for codes 51736 and 51741.**

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
51736	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	XXX	Direct Practice Expense Inputs
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	XXX	Direct Practice Expense Inputs

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The recommendations were developed by a Panel consisting of five physicians who represents urological practices from across the United States in single specialty groups in suburban and urban settings. They represent the states of Washington, Illinois, Virginia, New York, and Kentucky. The panel reviews current information, makes recommendations and these recommendations are submitted to the AMA.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Staff has pre- procedure contact with the patient to verify appointment and give patient instructions and education regarding the test. She makes sure the patient arrives to the facility with a comfortably full bladder. Once the patient arrives they are asked to remove their lower body clothing and given a gown to wear.

Intra-Service Clinical Labor Activities: The patient is asked to go into the bathroom. There is no other intra-service clinical work.

Post-Service Clinical Labor Activities: The clinical staff then cleans the bathroom.

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor: Complex uroflowmetry (eg, calibrated electronic equipment)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

The recommendations were developed by a Panel consisting of five physicians who represents urological practices from across the United States in single specialty groups in suburban and urban settings. They represent the states of Washington, Illinois, Virginia, New York, and Kentucky. The panel reviews current information, makes recommendations and these recommendations are submitted to the AMA.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Staff has pre- procedure contact with the patient to verify appointment and give patient instructions and education regarding the test. She makes sure the patient arrives to the facility with a comfortably full bladder. The staff calibrates the equipment and prepares the uroflow machine for the patient. Once the patient arrives they are asked to remove their lower body clothing and given a gown to wear.

Intra-Service Clinical Labor Activities: The patient is asked to sit on or stand in front of the uroflow chair. The clinical staff person instructs patient that after the staff person has left the room the patient should empty their bladder as fully as they possibly can. They are to knock on the door when they are finished. This gives the patient the privacy as close to their home bathroom as possible. Clinical staff then leaves the room. Once the patient knocks staff re-enters the room.

Post-Service Clinical Labor Activities: The clinical staff removes the printout from the uroflow machine and reviews the results with the physician. The clinical staff then cleans the equipment and surrounding areas and prepares the uroflow machine for the next patient.

	A	B	C	D	E	F	G
1	<b>AMA Specialty Society RVS Update Committee Recommendation</b>						
2				51736		51741	
3	Meeting Date: September/October 2010				Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	Complex uroflowmetry (eg, calibrated electronic equipment)	
4	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD		XXX	Only		Only	
6	TOTAL CLINICAL LABOR TIME		L037D	9.0		9.0	
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0		0.0	
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		L037D	9.0		9.0	
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0		0.0	
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	No pre-service clinical staff time						
13	End: When patient enters office/facility for surgery/procedure						
14	SERVICE PERIOD						
15	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
16	Provide pre-service education		L037D	2		2	
17	Prepare room, equipment, supplies		L037D	2		2	
18	Intra-service						
19	No intra-service clinical staff time		L037D	0		0	
20	Post-Service						
21	Clean room/equipment by physician staff		L037D	5		5	
22	End: Patient leaves office						
23	POST-SERVICE Period						
24	Office visits						
25	List Number and Level of Office Visits						
26	99211 16 minutes			16	0	0	
27	99212 27 minutes			27	0	0	
28	99213 36 minutes			36	0	0	
29	99214 53 minutes			53	0	0	
30	99215 63 minutes			63	0	0	
31	Other						
32	Total Office Visit Time				0	0	
33	Other Activity (please specify)						
34	End: with last office visit before end of global period						
35	MEDICAL SUPPLIES				Unit		
36	Paper, recording, roll (per foot)	SK060				1	
37	Beaker, 250 ml	SL018		1		1	
38	Pack, minimum multi-specialty visit	SA048		1		1	
39	Disinfectant spray	SM012				1	
40	Sanitizing cloth-wipe (surface, instruments, equipment)	SM022				1	
41	Towel, paper (Bounty) (per sheet)	SK082				4	
42	Equipment		Time				
43	Uroflowmeter, digital	EQ259	10 min			1	

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

*Originated from the RUC Relativity Assessment - Different Performing Specialty from Survey Screen, High Volume Growth Screen and Codes Reported Together 75% or More Screen.*

October 2010

**Spine/Brain Pump, Analyze with Refill and Maintenance – Practice Expense Only**

In April 2010, the following services were identified through the RUC's Relativity Assessment Workgroup' Different Performing Specialty from Survey Screen, High Volume Growth Screen and Codes Reported Together 75% or More Screen.

62367 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming*

62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming*

95990 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);*

95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by a physician*

The Relativity Assessment Workgroup referred the above set of codes to the CPT Editorial Panel to delete 62368 and separate into 3 codes. In addition, the Workgroup referred the services to the Practice Expense Subcommittee for review in October 2010 to remove duplication in their direct practice expense inputs. In October 2010, the RUC did not review the direct inputs for this code set as the specialty informed the RUC that a coding proposal has been submitted for discussion at the October 2010 CPT Editorial Panel meeting. In October 2010 the CPT Editorial Panel created two codes and revised three to distinguish and provide specificity to the this group of codes. An additional parenthetical was also added so that codes 95990-95991 are not reported in conjunction with 62367-6236X3. In February 2011 the RUC will review the physician work and practice expense for these Codes 62367 and new codes 6236X2 and 6236X3.

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming <u>or refill</u>	XXX	Direct Practice Expense Inputs, Postponed until February 2011

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
62368	<p>with reprogramming            (For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, use 95990-95991)</p> <p><u>(Do not report 62367-6236X3 in conjunction with 95990, 95991)</u>  <u>(For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy without reprogramming, see 95990, 95991)</u></p>	XXX	Direct Practice Expense Inputs, Postponed until February 2011
95990	<p>Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);</p> <p><del>(For analysis and/or reprogramming of implantable infusion pump, see 62367-62368)</del></p> <p><del>(For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy [eg, chemotherapy or insulin], use 96522)</del></p>	XXX	Direct Practice Expense Inputs duplication issue resolved through CPT
95991	<p>administered by physician-requiring physician's skill  <u>(Do not report 95990-95991 in conjunction with 62367-6236X3)</u>  <u>(For analysis and/or reprogramming of implantable infusion pump, see 6236X3)</u>  <u>(For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy [eg, chemotherapy or insulin], use 96522)</u></p>	XXX	Direct Practice Expense Inputs duplication issue resolved through CPT

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
*Originated from the RUC Relativity Assessment – High IWPUT Screen*

October 2010

**Treatment of Retinal Lesion or Choroid**

In February 2008, the RUC identified CPT codes 67210 and 67220 as potentially misvalued through the High IWPUT screen. The specialty, at the October 2009 RUC meeting, requested a change in the global period for this service. CMS subsequently rejected this proposal and the specialty surveyed these codes for the October 2010 RUC meeting.

***67210 Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation***

The RUC analyzed the survey results from 39 Ophthalmologists and agreed that the survey respondents overestimated the physician work involved in the service. Therefore, to develop recommendations for these services the RUC compared the surveyed code to the reference CPT code 67221 *Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy (includes intravenous infusion)* (work RVU= 3.45 and intra time of 15 minutes). The RUC noted that these two services have very similar physician work intensity and complexity with identical intra-service times, 15 minutes. Therefore, the RUC determined that these service's values should be identical. However, the RUC noted that CPT code 67221 is a 000 day global service, while CPT code 67210 is a 090 day global service. To determine the value for this service, the RUC agreed to add the typical amount of post operative visits, three 99213 office visits (total work RVU= 2.91), to the base work value of 3.45. Using magnitude estimation,  $3.45 + 2.91$ , the RUC recommends a work value of 6.36 for CPT code 67210.

To ensure the value for this service is relative to similar services, the RUC compared CPT code 67120 to the Key Reference Service code 67228 *Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation* (work RVU= 13.82). The RUC noted that when this service was reviewed in February 2007, the value was based off 2.4 treatments. If the work value and times are adjusted to a per single treatment session, the service has a work value of 5.76 and intra-service time of 25 minutes. The RUC agreed with the specialty that compared with the reference code, the surveyed code requires greater physician mental effort, complexity, technical skill and risk due to the fact that this laser treatment is administered in the macular area rather than the more peripheral retinal area treated by 67228. Given this, the RUC agreed that the recommended work value of 6.36 for code 67210 appropriately places this service in the proper rank order relative to other services performed by Ophthalmologists. Finally, the RUC noted that the recommended value is a significant reduction, 33 percent, from the current value of 9.45 and the recommended IWPUT for this service is 0.199 a significant reduction from the initial IWPUT of 0.336. **The RUC recommends a work RVU of 6.36 for CPT code 67210.**

**67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions**

The RUC analyzed the survey results from 46 Ophthalmologists and agreed that the survey respondents overestimated the physician work involved in the service. Therefore, to develop recommendations for these services the RUC reviewed this service in comparison to the other service in the family, code 67210, and agreed that the physician work intensity is the same for both services. Given this, the RUC took the same methodology they used for code 67210 and applied it directly to code 67220, deriving a work value of 6.36 for CPT code 67220. The RUC noted that the recommended value is a significant reduction, 44 percent, from the current value of 14.39 and the recommended IPUT for this service is 0.183 a significant reduction from the initial IPUT of 0.389. **The RUC recommends a work RVU of 6.36 for CPT code 67220.**

CPT Code (•New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
Codes 67208, 67210, 67218, 67220, 67227, 67228, 67229 include treatment at one or more sessions that may occur at different encounters. These codes should be reported once during a defined treatment period.				
67210		Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation	090	6.36
67220		Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions	090	6.36

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:67210  
 Global Period: 090

Tracking Number

Specialty Society Recommended RVU: **7.80**  
 RUC Recommended RVU: **6.36**

CPT Descriptor: Destruction of Localized Lesion of Retina (e.g., macular edema, tumors), one or more sessions; photocoagulation

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 56-year old male with long-standing Type 2 diabetes mellitus has noted decreased vision. Clinically significant macula edema is present. Focal photocoagulation is administered to the macula. Recovery is monitored during laser photocoagulation treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 5% , In the ASC 5%, In the office 90%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 15%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 2%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient's vision is measured, pupils are dilated, and anesthesia (topical or retrobulbar) is applied. Fluorescein angiograms are reviewed with stereoscopy and placed in position to be continuously monitored during laser photocoagulation treatment.

Description of Intra-Service Work: Laser photocoagulation is performed, using projection of fluorescein angiogram as a guide. Each leaking microaneurysm is identified and treated with respect to the papillomacular bundle and foveal avascular zone. After closing each leaking microaneurysm, attention is directed to areas of capillary dropout and areas of diffuse leakage where photocoagulation is applied in a "grid fashion." For each burn, surgeon assesses the response to patient's motion, anterior segment opacity affecting the intensity of laser reaching lesion, thickness of lesion, and tissue reaction to treatment. The surgeon pauses frequently between burns to ensure continued steadiness of both patient and surgeon.

Description of Post-Service Work: Follow-up begins immediately following treatment. Surgeon assesses adequacy of treatment and checks for signs of complication such as bleeding, retinal tears, breaks in Bruch's membrane, or physician error. The patient is counseled regarding postoperative care of treated eye. Patient is counseled regarding the fact the treated eye will be blurred for a period of time and great care should be taken in performing various tasks, including driving. Follow-up visits are scheduled.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2010				
<b>Presenter(s):</b>	Stephen A. Kamenetzky and William F. Mieler, M.D.				
<b>Specialty(s):</b>	American Academy of Ophthalmologists and American Society of Retina Specialists				
<b>CPT Code:</b>	67210				
<b>Sample Size:</b>	270	<b>Resp N:</b>	39	<b>Response:</b> 14.4 %	
<b>Sample Type:</b>	Random Additional Sample Information: Random samples were drawn from the ASRS membership as well as from AAO members who indicate retina subspecialty.				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
<b>Service Performance Rate</b>	20.00	64.50	<b>115.00</b>	200.00	600.00
<b>Survey RVW:</b>	4.60	7.80	<b>11.27</b>	13.82	17.32
<b>Pre-Service Evaluation Time:</b>			<b>10.00</b>		
<b>Pre-Service Positioning Time:</b>			<b>5.00</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			<b>2.00</b>		
<b>Intra-Service Time:</b>	5.00	10.00	<b>15.00</b>	19.00	30.00
<b>Immediate Post Service-Time:</b>	<b>5.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<b>0.00</b>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<b>0.00</b>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<b>69.00</b>	99211x 0.00	12x 0.00	13x 3.00	14x 0.00
Prolonged Services:	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

<b>CPT Code:</b>	67210	<b>Recommended Physician Work RVU: 7.80</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
Pre-Service Evaluation Time:		<b>10.00</b>	<b>17.00</b>	<b>-7.00</b>
Pre-Service Positioning Time:		<b>5.00</b>	<b>1.00</b>	<b>4.00</b>
Pre-Service Scrub, Dress, Wait Time:		<b>2.00</b>	<b>5.00</b>	<b>-3.00</b>
Intra-Service Time:		<b>15.00</b>		
Immediate Post Service-Time:	<b>5.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
Critical Care time/visit(s):	<b>0.00</b>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<b>0.00</b>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<b>69.00</b>	99211x 0.00	12x 0.00	13x 3.00
Prolonged Services:	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
67228	090	13.82	RUC Time

CPT Descriptor Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation

**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.

<u>MPC CPT Code 1</u>	Most Recent		
	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
57155	090	6.87	RUC Time
<u>CPT Descriptor 1</u> Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy			
<u>MPC CPT Code 2</u>	Most Recent		
	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
46262	090	7.91	RUC Time
<u>CPT Descriptor 2</u> Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed			

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 56.4 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 67210	<u>Key Reference CPT Code:</u> 67228	<u>Source of Time</u> RUC Time
Median Pre-Service Time	17.00	20.00	
Median Intra-Service Time	15.00	25.00	
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	69.0	69.00	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>106.00</b>	<b>119.00</b>	

Other time if appropriate

(single)

INTENSITY/COMPLEXITY MEASURES (Mean)

(of those that selected Key Reference code)

Mental Effort and Judgment (Mean)

The number of possible diagnosis and/or the number of management options that must be considered

4.45

4.35

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

4.55

4.40

Urgency of medical decision making

4.40

4.35

Technical Skill/Physical Effort (Mean)

Technical skill required

4.95

4.55

Physical effort required

4.00

4.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality

4.70

4.60

Outcome depends on the skill and judgment of physician

4.85

4.55

Estimated risk of malpractice suit with poor outcome

4.45

4.20

INTENSITY/COMPLEXITY MEASURESCPT CodeReference Service 1Time Segments (Mean)

Pre-Service intensity/complexity

4.35

4.25

Intra-Service intensity/complexity

4.40

4.55

Post-Service intensity/complexity

3.65

4.00

**Additional Rationale and Comments**

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.

\* To ensure appropriate comparison of the single session surveyed code (67210) to the reference code and after receiving approval from the RUC staff, the times for the reference code 67228 have been converted to single session rather than 2.4 sessions captured in the RUC database.

This code (67210) was selected for review because of a high IWPPUT. The code was initially considered by the RUC in the First Five Year Review (1995) along with the companion code 67220 which is also being reviewed at this meeting. At that time the RUC recognized that the high IWPPUT of the code was driven in large part by two factors: retreatments which take place during the 90-day global period and the innate complexity and risk of the procedure. The RUC rationale from that meeting stated the following:

*These retreatments are done during the post-service period, so they are not reflected in the analysis of IWPPUT. In addition, the IWPPUT is appropriately high because the procedure subjects every treated patient to an immediate and substantial risk of vision loss or blindness.*

It was also noted that the 1995 survey revealed a bimodal distribution consistent with the fact that the code was used to describe treatment of two distinct diseases (diabetic macular edema and age-related macular degeneration), which required different degrees of physician work. The RUC recommended that the code be referred to CPT Editorial Panel and two codes were created (67210 and 67220) which allowed coding the treatment of each disease separately, but kept the "one or more sessions" language in the descriptor for both. The codes were reconsidered by the RUC in 1998 and work values were developed in a revenue-neutral fashion using the building block method and clinically-derived assumptions regarding the retreatment rate during the global period. This information is outlined in the RUC rationale below:

*CPT code 67210 Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; photocoagulation) was closely analyzed during the Five Year Review. There was considerable concern with CPT code 67210 as there was a bimodal distribution of this procedure since the specific service being performed was for two distinct diagnoses. As a result, 67210 was referred to CPT and split into two codes, the revised 67210 and 67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization), one or more session, photocoagulation (laser).*

*In order to split the RVWs for 67210 into the two new codes each representing a distinct patient population and requiring different amounts of work while maintaining Medicare Budget neutrality, both survey data and Harvard methodology were used to calculate the recommended RVWs. The following estimates were made to examine the relationship between revised 67210 and 67220: the ratio between 67210 to 67220 previously reported as 67210 is 2.5 to 1.0; revised 67210 will require multiple sessions in approximately 20% of the patients treated; 67220 will require multiple sessions in approximately 50% of the patients treated; and the survey median RVW ratio of 7.0 to 9.0 accurately reflects the differences in work between revised 67210 and 67220 for ONE session.*

*The Harvard methodology was then used to calculate intra-service RVWs by valuing pre-service work and HCFA methodology to value post-service work global E/M work. For the revised 67210, one additional session and one additional office visit equals 4.72 rvus or .92 rvus for a 20% retreatment rate; and for 67220, one additional session and two additional office visits equal 5.64 rvus or 2.82 rvus for a 50% retreatment rate. Adding these calculated rvus for retreatments (.92 and 2.82) to each code, results in a revised proportion of 7.94 to 11.82 RVWs based on the survey median RVWs of 7.0 and 9.0 for the two codes. These rvus are then multiplied by the estimated frequency for each code, and sum is divided into the 1996 total billed rvus, to arrive at an adjustment factor of 1.11. This adjustment factor is then multiplied by 7.94 and 11.82 to arrive at a RUC recommended RVW of 8.82 for the revised 67210 and a recommended RVW of 13.13 for 67220. These recommended values maintain budget neutrality.*

The analysis by the RUC above accepted the median WRVU of the survey (7.00) as accurately reflecting the work for a SINGLE laser session and used in a building block method to construct the work value that is in place today. As the rationale indicates, using the building block method, a treatment plus an office visit was equal to 4.72 WRVU. The 99213 office visit at that time was valued at 0.67 RVU, which would make the intraservice work of a single laser treatment have a WRVU value of  $4.72 - 0.67 = 4.05$ .

The code, 67210, was resurveyed. There were 39 respondents for a response rate of 14.4%. Ninety-two percent of the respondents found the vignette to be typical. The survey median WRVU was 11.5 with the 25<sup>th</sup> percentile WRVU 7.8. Preservice time was 17 minutes from the survey and these times were used rather than the 23 minutes in non-facility package 6. The median intraservice time was 15 minutes with 5 minutes of postservice time. The survey indicated that there were three 99213 visits during the global period at approximately 1, 2 and 3 month postoperative intervals. This code is not typically performed with an EM code on the day of the procedure. The reference code chosen most frequently was 67228 - Treatment of extensive or progressive retinopathy, 1 or more sessions; (e.g., diabetic retinopathy), photocoagulation which

was reviewed by the RUC in Feb 2007. It has a WRVU of 13.82 based on 2.4 treatments in 90 days which converts to 5.76 WRVU per single treatment session. When compared with the reference code, the surveyed code (67210) required greater mental effort, complexity, technical skill and risk than the reference service due to the fact that this laser treatment is administered in the macular area rather than the more peripheral retinal area treated by 67228.

An expert panel of the Health Policy Committee of AAO which was familiar with both the procedure and the RUC process reviewed the results. Several changes in clinical practice have developed since 1998 which makes this procedure different today.. Retreatment with laser during the 90-day global period had largely been replaced with intravitreal injections of anti-VEGF agents if supplemental therapy is needed for unresolved macular edema. A recent peer reviewed paper in *Ophthalmology*<sup>1</sup>, establishes this treatment pattern as the current standard of care. Therefore the typical patient would now receive only one treatment during the 90-day global period.

The panel considered the RUC valuation of several other retinal laser codes (see Table):

CPT 67228 (90-day global), the reference code valued by the RUC in 2007, has a value per treatment session of 13.82/2.4 RVU= 5.76 of which 3.79 RVU represents the intraservice work (9.10 RVU total ISW from the IPUT formula/2.4 treatments per 90 days). As noted above, this code has lower mental effort, complexity, technical skill and risk scores when compared with the surveyed code. 67228 involves extensive laser treatment of the entire peripheral retina rather than the central macular area. It takes longer to do but has a much lower risk of iatrogenic damage to central visual acuity.

CPT 67145 (90-day global) (*Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)*) is a Harvard valued 90 day global code with three 99213 post op visits and a WRVU of 6.32. It involves laser treatment of a limited area of the peripheral retina rather than the vision-critical macular area, making this procedure much less complex and intense when compared with the surveyed code. The intraservice work for this code is 2.63 RVU.

CPT 67221 (000 global) *Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes intravenous infusion)* is a 000 global with a value of 3.24 after removal of .21 WRVU for the intravenous infusion. If 3-99213 visits are added to convert to a 90 day global, the value becomes 6.15 RVU. Although this code involves laser treatment of the macular area, it is less intense than 67210 because it involves the prolonged aiming of the laser at a single spot in the macular area rather than placing multiple laser burns (50 on average) in a grid or focal pattern in this vision-critical area.

We are aware that the IPUT for this procedure remains high with the work value we have recommended. We continue to believe that the IPUT is not a reliable metric when used to value high-intensity short-duration procedures, a position with which CMS agrees (*Federal Register*; Vol. 74 No. 226, Nov. 25, 2009, pg. 61776.) We also believe, along with the originators of the IPUT concept, that the method is most reliable when used to compare services within a single specialty or subspecialty and that direct cross-specialty comparisons of IPUTs for procedures with widely disparate pre-, intra- and post-service times produces unreliable results which should not be used by the RUC to evaluate work recommendations. Ophthalmic procedures have generally higher IPUTs than those for other specialties because they are high-intensity short-duration procedures with low pre-and post service times. Nonetheless, the IPUT for this procedure is, when evaluated on a magnitude estimation basis using values previously approved by the RUC, very much in line. Ophthalmic injection codes have a RUC-approved IPUT value of 0.21. The IPUT for 67210 is higher because the mental effort and judgment, technical skill, physical effort and iatrogenic risk are significantly higher.

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<sup>1</sup> The Diabetic Retinopathy Clinical Research Network: Writing Committee: Michael J. Elman, MD; Lloyd Paul Aiello, MD, PhD, et. al Randomized Trial Evaluating Ranibizumab Plus Prompt or Deferred Laser or Triamcinolone Plus Prompt Laser for Diabetic Macular Edema. *Ophthalmology* 2010;117:1064–1077.

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 67210

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 1000000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated from Medicare utilization

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
133,285 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. Medicare/RUC database.

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 67210

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:67220  
 Global Period: 090

Tracking Number

Specialty Society Recommended RVU: **8.11**  
 RUC Recommended RVU: **6.36**

CPT Descriptor: Destruction of localized lesion of chorod (e.g., choroidal neovascularization); photocoagulation (e.g., laser) one or more sessions

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 69-year-old patient with a juxtafoveal choroidal neovascular membrane is treated with photocoagulation using a slit lamp biomicroscopic delivery system. The location of treatment application is guided by reference during the procedure to the results of a preoperative fluorescein angiogram. Recovery and visual acuity are monitored.

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

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 3% , In the ASC 3%, In the office 94%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Patient's vision is measured, pupils are dilated, and anesthesia (topical or retrobulbar) is applied. Fluorescein angiograms are reviewed with stereoscopy and to determine extent of the lesion to be treated.

Description of Intra-Service Work: Laser photocoagulation is performed, using projection of fluorescein angiogram as a guide. The lesion area is subjected to multiple laser burns. For each burn, surgeon assesses and responds to patient's motion, anterior segment opacity affecting the intensity of laser reaching lesion, thickness of lesion, and tissue reaction to treatment. Surgeon pauses frequently between burns to ensure continued steadiness of both patient and surgeon.

Description of Post-Service Work: Follow-up begins immediately. Surgeon assesses adequacy of treatment and checks for complication such as bleeding, retinal tears or tears of retinal pigment epithelium. Within a few minutes following treatment, pre- and post treatment photographs are compared to ensure that all of the choroidal neovascular membrane was adequately treated, including a 100 micron border. If lesion is judged to be inadequately treated, the patient is taken back to laser, and additional laser photocoagulation treatment is applied to the inadequately treated area. Follow-up visits are scheduled monthly for the next 3 months. Surgeon evaluates adequacy of treatment using photos, fluorescein angiography (paid separately), and ocular examination. Complications, persistence and recurrence are re-treated as necessary, following additional counseling and cost/benefit assessment. Re-treatment is required less than 50 percent of the time.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Stephen A. Kamenetzky, M.D. and William F. Mieler, M.D.				
Specialty(s):	American Academy of Ophthalmology and American Society or Retina Specialists				
CPT Code:	67220				
Sample Size:	350	Resp N:	46	<b>Response:</b> 13.1 %	
Sample Type:	Random Additional Sample Information: Random samples were drawn from the ASRS membership as well as from AAO members who indicate retina subspecialty				
	<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>	0.00	5.00	11.00	30.00	200.00
<b>Survey RVW:</b>	5.00	12.37	13.91	15.00	33.23
<b>Pre-Service Evaluation Time:</b>			15.00		
<b>Pre-Service Positioning Time:</b>			5.00		
<b>Pre-Service Scrub, Dress, Wait Time:</b>			3.50		
<b>Intra-Service Time:</b>	5.00	10.00	15.00	20.00	30.00
<b>Immediate Post Service-Time:</b>	<b><u>10.00</u></b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>69.00</u>	99211x 0.00	12x 0.00	13x 3.00	14x 0.00
Prolonged Services:	<u>0.00</u>	55x 0.00	56x 0.00	57x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 6 - NF Procedure with sedation/anesthesia care

CPT Code:	67220	Recommended Physician Work RVU: 8.11		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
Pre-Service Evaluation Time:		15.00	17.00	-2.00
Pre-Service Positioning Time:		5.00	1.00	4.00
Pre-Service Scrub, Dress, Wait Time:		3.50	5.00	-1.50
Intra-Service Time:		15.00		
<b>Immediate Post Service-Time:</b>	<b><u>10.00</u></b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>69.00</u>	99211x 0.00	12x 0.00	13x 3.00
Prolonged Services:	<u>0.00</u>	55x 0.00	56x 0.00	57x 0.00

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
67228	090	13.82	RUC Time

CPT Descriptor Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
57155	090	6.87	RUC Time	4,833

CPT Descriptor 1 Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
43269	000	8.20	RUC Time	18,220

CPT Descriptor 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 67.3 %

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 67220	<u>Key Reference CPT Code:</u> 67228	<u>Source of Time</u> RUC Time
Median Pre-Service Time	23.50	20.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	10.00	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	69.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	117.50	119.00	

Other time if appropriate		single
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**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

4.68

4.16

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

4.71

4.19

Urgency of medical decision making

4.84

4.39

**Technical Skill/Physical Effort (Mean)**

Technical skill required

4.87

4.19

Physical effort required

4.06

4.16

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

4.90

4.26

Outcome depends on the skill and judgment of physician

4.90

4.19

Estimated risk of malpractice suit with poor outcome

4.44

4.06

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

4.61

4.19

Intra-Service intensity/complexity

4.35

4.45

Post-Service intensity/complexity

4.29

3.94

**Additional Rationale and Comments**

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

- \* To ensure appropriate comparison of the single session surveyed code (67210) to the reference code and after receiving approval from the RUC staff, the times for the reference code 67228 have been converted to single session rather than 2.4 sessions captured in the RUC database.

This code, 67220, was selected for review because of a high IWPUT. During the first First Five-Year Review in 1995, CPT 67210, from which this code was derived and which is also being considered at this meeting, was reviewed and two issues were raised. The first was the high IWPUT. At that time the RUC recognized that the high IWPUT of the code was driven in large part by two factors: retreatments which take place during the 90-day global period and the innate complexity and risk of the procedure. The RUC rationale from that meeting stated the following:

*These retreatments are done during the post-service period, so they are not reflected in the analysis of IWPUT. In addition, the IWPUT is appropriately high because the procedure subjects every treated patient to an immediate and substantial risk of vision loss or blindness [emphasis added]*

It was also noted that the 1995 survey revealed a bimodal distribution consistent with the fact that the code was used to describe treatment of two distinct diseases (diabetic macular edema and age-related macular degeneration), which required different degrees of physician work. The RUC recommended that the code be referred to CPT editorial panel and two codes were created (67210 and 67220) which allowed coding the treatment of each disease separately, but kept the "one or more sessions" language in the descriptor for both. The codes were reconsidered by the RUC in 1998 and work values were developed in a revenue-neutral fashion using the building block method and clinically-derived assumptions regarding the retreatment rate during the global period. This information is outlined in the RUC rationale below:

*CPT code 67210 Destruction of localized lesion of retina (eg, macular edema, tumors), one or more sessions; photocoagulation) was closely analyzed during the Five Year Review. There was considerable concern with CPT code 67210 as there was a bimodal distribution of this procedure since the specific service being performed was for two distinct diagnoses. As a result, 67210 was referred to CPT and split into two codes, the revised 67210 and 67220 Destruction of localized lesion of choroid (eg, choroidal neovascularization), one or more session, photocoagulation (laser).*

*In order to split the RVWs for 67210 into the two new codes each representing a distinct patient population and requiring different amounts of work while maintaining Medicare Budget neutrality, both survey data and Harvard methodology were used to calculate the recommended RVWs. The following estimates were made to examine the relationship between revised 67210 and 67220: the ratio between 67210 to 67220 previously reported as 67210 is 2.5 to 1.0; revised 67210 will require multiple sessions in approximately 20% of the patients treated; 67220 will require multiple sessions in approximately 50% of the patients treated; and the survey median RVW ratio of 7.0 to 9.0 accurately reflects the differences in work between revised 67210 and 67220 for ONE session.*

*The Harvard methodology was then used to calculate intra-service RVWs by valuing pre-service work and HCFA methodology to value post-service work global E/M work. For the revised 67210, one additional session and one additional office visit equals 4.72 rvus or .92 rvus for a 20% retreatment rate; and for 67220, one additional session and two additional office visits equal 5.64 rvus or 2.82 rvus for a 50% retreatment rate. Adding these calculated rvus for retreatments (.92 and 2.82) to each code, results in a revised proportion of 7.94 to 11.82 RVWs based on the survey median RVWs of 7.0 and 9.0 for the two codes. These rvus are then multiplied by the estimated frequency for each code, and sum is divided into the 1996 total billed rvus, to arrive at an adjustment factor of 1.11. This adjustment factor is then multiplied by 7.94 and 11.82 to arrive at a RUC recommended RVW of 8.82 for the revised 67210 and a recommended RVW of 13.13 for 67220. These recommended values maintain budget neutrality.*

CPT 67220 is used to describe the treatment of a subretinal neovascular membrane typically caused by age-related macular degeneration. The membrane is located near the fovea. In 1998 the survey median value of 9.0 WRVUs was accepted as fairly representing the work of a **single** treatment session. The assumption was that there would be 50% retreatment rate during the global period. Using the building block method, the RUC calculated a value for an additional laser session and along with 2 additional 99213 office visits to be 5.64 RVU. Each office visit was valued at 0.67 RVU at the time, indicating the actual **WRVU for the intraservice work of a single laser treatment session was 4.30.**

The code was resurveyed for this meeting. There were 46 respondents with a response rate of 13%. 85% considered the vignette to be typical. The survey **median WRVU was 13.91 with the 25<sup>th</sup> percentile WRVU 12.36.** **Preservice time was 23.5 minutes** from the survey which is the same as for package 6 for non-facility. We used the survey breakdown (15/5/3.5) rather than the distribution in the package (17/1/5) because the survey respondents felt that there was slightly less evaluation and DSW time and slightly more positioning time required to correctly align the patient at the laser. The **median intraservice time was 15 minutes with 10 minutes of postservice time.** The survey indicated that there were three 99213 visits during the global period at approximately 1, 2 and 3 month intervals. This code is not typically performed with an EM code on the day of the procedure.

The reference code chosen most frequently (67%) was 67228 - *Treatment of extensive or progressive retinopathy, 1 or more sessions; (eg, diabetic retinopathy), photocoagulation* which was reviewed by the RUC in Feb 2007. It has a WRVU of 13.82 based on 2.4 treatments in 90 days which converts to 5.76 WRVU per single treatment session. When compared with the reference code, the surveyed code required greater mental effort, complexity, technical skill and risk than the reference service due to the fact that this laser treatment is typically administered in the macular area rather than the more peripheral retinal area treated by 67228.

An expert panel of the Health Policy Committee of AAO which was familiar with both the procedure and the RUC process reviewed the results. Several changes in clinical practice have occurred since 1998 when 67220 was valued which makes this procedure different today. In 1998 use of the laser to treat juxtapfoveal lesions with the laser was the only effective treatment available for subretinal neovascularization. With the emergence of intravitreal anti-VEGF agents as an alternate and actually more effective treatment for subretinal neovascular membranes, lesions in very close proximity to the fovea are not treated as often with the laser as they were when the code was initially valued. This change in practice reduces the risk of significant visual loss to a level the consensus panel felt approximated that for 67210. It also reduces the time required for the treatment described by 67220. The re-treatment rate is also lower because the primary cause of treatment failure is inadequate treatment due to fear of foveal damage. When lesions further from the fovea are treated, the initial treatment can be more intense. The typical patient now would only require a single laser session. The number of laser applications is also about the same as for 67210. However for the neovascular membrane, only that specific portion of the retina is treated whereas for 67210 multiple laser burns are distributed over a wider area in the macular region.

The panel considered the RUC valuation of several other retinal laser codes to aid in valuation:

CPT 67228 (90-day global), the reference code valued by the RUC in 2007, has a value per treatment session of 13.82/2.4 RVU= 5.76 of which 3.79 RVU represents the intraservice work (9.10 RVU total ISW from the IWPUT formula/2.4 treatments per 90 days). As noted above, this code has lower mental effort, complexity, technical skill and risk scores when compared with the surveyed code. 67228 involves extensive laser treatment of the entire peripheral retina rather than the central macular area. It takes longer to do but has a much lower risk of iatrogenic damage to central visual acuity.

CPT 67145 (90-day global) (*Prophylaxis of retinal detachment (e.g., retinal break, lattice degeneration) without drainage, 1 or more sessions; photocoagulation (laser or xenon arc)*) is a Harvard valued 90 day global code with three 99213 post op visits and a WRVU of 6.32. It involves laser treatment of a limited area of the peripheral retina rather than the vision-critical macular area, making this procedure much less complex and intense when compared with the surveyed code. The intraservice work for this code is 2.63 RVU.

CPT 67221 (000 global) *Destruction of localized lesion of choroid (e.g., choroidal neovascularization); photodynamic therapy (includes intravenous infusion)* is a 000 global with a value of 3.24 after removal of .21 WRVU for the intravenous infusion. If 3-99213 visits are added to convert to a 90 day global, the value becomes 6.15 RVU. Although this code involves laser treatment of the macular area, it is less intense than 67210 because it involves the prolonged aiming of the laser at a single spot in the macular area rather than placing multiple laser burns (50 on average) in a grid or focal pattern in this vision-critical area.

Magnitude estimation using these RUC-valued codes as anchors confirms that the intra-service work of 67220 is more intense and complex than 67228, 67145 and 67221. As the RUC noted in previous reviews, "the procedure subjects every treated patient to an immediate and substantial risk of vision loss or blindness." This intensity difference when compared with the other RUC-reviewed laser codes justifies a higher work RVU based on the RUC definition of the components of work: time, mental effort and judgment, technical skill, physical effort and iatrogenic risk.

We are aware that the IPUT for this procedure remains high with the work value we have recommended (IPUT=.30). We continue to believe that the IPUT is not a reliable metric when used to value high-intensity short-duration procedures, a position with which CMS agrees (*Federal Register; Vol. 74 No. 226, Nov. 25, 2009, pg. 61776.*) We also believe, along with the originators of the IPUT concept, that the method is most reliable when used to compare services within a single specialty or subspecialty and that direct cross-specialty comparisons of IPUTs for procedures with widely disparate pre-, intra- and post-service times produces unreliable results which should not be used by the RUC to evaluate work recommendations. Ophthalmic procedures have generally higher IPUTs than those for other specialties because they are high-intensity short-duration procedures with low pre-and post service times. Nonetheless, the IPUT for this procedure is, when evaluated on a magnitude estimation basis using values previously approved by the RUC, very much in line. Ophthalmic injection codes have a RUC-approved IPUT value of 0.21. The IPUT for 67220 is high because the mental effort and judgment, technical skill, physical effort and iatrogenic risk are significantly higher.

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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.
- 

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 67220

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Ophthalmology

How often? Commonly

Specialty

How often?

Specialty	How often?
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Estimate the number of times this service might be provided nationally in a one-year period? 19000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated from Medicare utilization

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

12,904 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. Medicare/RUC database

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States?

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 67220

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

*Identified through the Codes Reported Together 75% or More Screen and CMS Fastest Growing Screen*

October 2010

**IMRT Related Services – Practice Expense Only**

**Duplicative Direct Practice Expense Inputs**

In April 2010, the RUC's Relativity Assessment Workgroup identified the following four intensity modulated radiation treatment delivery services for RUC practice expense review through its Codes Reported Together 75% or More Screen and CMS Fastest Growing Screen:

*76950 Ultrasonic guidance for placement of radiation therapy fields*

*77418 Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*

*77014 Computed tomography guidance for placement of radiation therapy fields*

*77421 Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy*

To assure there is no duplication in practice expense, the Workgroup referred the practice expense components to the RUC for review of potential practice expense input duplication, as the services were reviewed at separate meetings and are frequently reported together.

In October 2010, the RUC examined the direct inputs of the four services together and made minor revisions to eliminate duplicative clinical labor, supplies, and equipment typically used. **In addition, the RUC recommended that the CPT Editorial Panel add the parenthetical after CPT code 77421; (Do not report 77421 more than once per treatment delivery session) to add further clarification to the reporting of this service. The RUC recommends the attached direct practice expense inputs for codes 76950, 77014, 77418, and 77421.**

**Direct Practice Expense Inputs - Fiducial Screws**

In the 2011 proposed Medicare Physician Fee Schedule (MPFS), page 40063, the Centers for Medicare and Medicaid Services (CMS) identified the fiducial screws (CMS Supply Code SD073) as a high-cost supply item and requested the RUC to review this practice expense input with respect to their inclusion as practice expense inputs within CPT codes *77301 Intensity modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications* and *77011 Computed tomography guidance for stereotactic localization*.

In October 2010, the RUC's Practice Expense Subcommittee met and discussed the CMS request. After review of the practice expense inputs for CPT code 77011, the RUC's Practice Expense Subcommittee and the RUC agreed that the fiducial screws are not considered typical for this procedure and therefore can be removed from the code's supply list. In addition, fiducial screws should be removed from the list of supplies as a recent CMS transmittal this year (effective as of November 6th 2010) (<https://www.cms.gov/transmittals/downloads/R745OTN.pdf>) clearly instructs Medicare payers to reimburse fiducial markers with HCPCS code A4648 as a separately billable item when used with CPT codes for the insertion of fiducial markers for IMRT (ie., 77301). **The RUC therefore recommends that fiducial screws (SD073) be removed from the list of practice expense inputs for CPT codes 77011 and 77301.**

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
76950	Ultrasonic guidance for placement of radiation therapy fields  (For placement of interstitial device[s] for radiation therapy guidance, see 31627, 32553, 49411, 55876)	XXX	Direct Practice Expense Inputs
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session  (For intensity modulated treatment planning, use 77301)  (For compensator-based beam modulation treatment delivery, use Category III code 0073T)	XXX	Direct Practice Expense Inputs
77011	Computed tomography guidance for stereotactic localization	XXX	Direct Practice Expense Inputs
77014	Computed tomography guidance for placement of radiation therapy fields  (For placement of interstitial device[s] for radiation therapy guidance, see 31627, 32553, 49411, 55876)	XXX	Direct Practice Expense Inputs
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications  (Dose plan is optimized using inverse or forward planning technique for modulated beam delivery [eg, binary, dynamic MLC] to create highly conformal dose distribution. Computer plan distribution must be verified for positional accuracy based on dosimetric verification of the	XXX	Direct Practice Expense Inputs

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
	intensity map with verification of treatment set-up and interpretation of verification methodology)		
77421	<p>Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy            (Do not report 77421 in conjunction with 77432, 77435)  <u>(Do not report 77421 more than once per treatment delivery session)</u>            (For placement of interstitial device[s] for radiation therapy guidance, see 31627, 32553, 49411, 55876)</p>	XXX	Direct Practice Expense Inputs and Referral to the CPT Editorial Panel

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Ultrasonic guidance for placement of radiation therapy fields

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

*ASTRO used an expert panel to develop the PE recommendations for CPT code 76950. The expert panel was comprised of physicians, representing both the facility and nonfacility settings. The physicians on the panel work in varying practice settings (i.e. academic, community hospital, community cancer centers, and private practice).*

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No pre-service activities.

Intra-Service Clinical Labor Activities:

Radiation Therapist:

- Prepare room, equipment, and supplies
- Prepare and position patient, monitor patient
- Perform procedure

Post-Service Clinical Labor Activities:

Radiation Therapist:

- Clean room and equipment

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

CPT Long Descriptor:

Computed tomography guidance for placement of radiation therapy fields

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

*ASTRO used an expert panel to develop the PE recommendations for CPT code 77014. The expert panel was comprised of physicians, representing both the facility and nonfacility settings. The physicians on the panel work in varying practice settings (i.e. academic, community hospital, community cancer centers, and private practice).*

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No pre-service activities

Intra-Service Clinical Labor Activities:

Radiation Therapist:

- Prepare room, equipment, and supplies
- Prepare and position patient
- Perform Procedure

Post-Service Clinical Labor Activities:

Radiation Therapist:

- Process fused images
- Review fused CT with MD

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**CPT Long Descriptor:**

Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session

**Global Period: XXX**

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

*ASTRO used an expert panel to develop the PE recommendations for CPT code 77418. The expert panel was comprised of physicians, representing both the facility and nonfacility settings. The physicians on the panel work in varying practice settings (i.e. academic, community hospital, community cancer centers, and private practice).*

Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:**

No pre-service activities.

**Intra-Service Clinical Labor Activities:**

RN/LPN/MTA: greets patient and provides gowning

Radiation Therapist: performs procedure

**Post-Service Clinical Labor Activities:**

The Radiation Therapist

- Conduct charting
- Follow-up with patient and family

**AMA/Specialty Society Update Process  
Practice Expense Summary of Recommendation  
Non Facility Direct Inputs**

**CPT Long Descriptor:**

Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:

*ASTRO used an expert panel to develop the PE recommendations for CPT code 77421. The expert panel was comprised of physicians, representing both the facility and nonfacility settings. The physicians on the panel work in varying practice settings (i.e. academic, community hospital, community cancer centers, and private practice).*

Please describe in detail the clinical activities of your staff:

**Pre-Service Clinical Labor Activities:**

No pre-service activities.

**Intra-Service Clinical Labor Activities:**

Radiation Therapist:

Prepare room, equipment, supplies

Prepare and position patient/ monitor patient

Perform procedure

**Post-Service Clinical Labor Activities:**

No post-service activities.

	A	B	C	D	E	F	G	H	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommendation										
2	Meeting Date: September 2010			77418	77421	76950		77014			
3		CMS	Staff	IMRT treatment delivery	Stereoscopic x-ray guidance for radiation	US guidance for radiation		CT guidance for radiation			
4	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
5	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			68.0	0.0	24.0	0.0	22.0	0.0	18.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			63.0	0.0	24.0	0.0	22.0	0.0	18.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10	PRE-SERVICE										
11	Start: Following visit when decision for surgery or procedure made										
12	Complete pre-service diagnostic & referral forms										
13	Coordinate pre-surgery services										
14	Schedule space and equipment in facility										
15	Provide pre-service education/obtain consent										
16	Follow-up phone calls & prescriptions										
17	Other Clinical Activity (please specify)										
18	End: When patient enters office/facility for surgery/procedure										
19	SERVICE PERIOD										
20	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
21	Review charts	L037D	RN/LPN/MTA	3							
22	Greet patient, provide gowning, ensure appropriate medical records are available	L050C	Radiation Therapist		2	2		2			
23	Obtain vital signs	L050C	Radiation Therapist		2	2		2			
24	Provide pre-service education/obtain consent	L050C	Radiation Therapist		20	15		10			
25	Prepare room, equipment, supplies										
26	Setup scope (non facility setting only)										
27	Prepare and position patient/ monitor patient/ set up IV										
28	Sedate/apply anesthesia										
29	Intra-service										
30	Perform procedure										
31	Post-Service										
32	Monitor pt. following service/check tubes, monitors, drains										
33	Clean room/equipment by physician staff										
34	Clean Scope										
35	Clean Surgical Instrument Package										
36	Complete diagnostic forms, lab & X-ray requisitions										
37	Review/read X-ray, lab, and pathology reports										
38	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions										
39	Discharge day management										
40	Other Clinical Activity (please specify)										
41	Process films and review study with interpreting MD prior to patient discharge	L050C	Radiation Therapist							4	
42	End: Patient leaves office										
43	POST-SERVICE Period										

	A	B	C	D	E	F	G	H	I	J	K
2	Meeting Date: September 2010			77418		77421		76950		77014	
3		CMS	Staff	IMRT treatment delivery	Stereoscopic x-ray guidance for radiation		US guidance for radiation		CT guidance for radiation		
4	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
44	Start: Patient leaves office/facility										
45	Charting	L050C	Radiation Therapist	5							
46	Conduct phone calls/call in prescriptions										
56	Other Activity (please specify)										
57	End: with last office visit before end of global period										
58	MEDICAL SUPPLIES		Unit								
59	PEAC multispecialty supply package	SA048		1							
60	drape, non-sterile, sheet 40in x 60in	SB006		1							
61	Earplugs	SJ018		1							
62	skin marking ink (tattoo)	Sk073		2							
63	gauze, non-sterile 4in x 4in	SG051		4							
64	alcohol, ethyl, denatured	SL006		7							
65	Foley Catheter	SD024		1							
66	syringe 10-12ml	SC051		1							
67	lubricating jelly (K-Y) (5gm uou)	SJ032		2							
68	tape, surgical paper 1in (Micropore)	SG079		8							
69	x-ray ID card (flashcard)	SK093		2							
70	film, x-ray 14in x 17in	SK034		2							
71	swab-pad, alcohol	SJ053			2						
72	lubricating jelly (K-Y) (5gm uou)	SJ032						2			
73	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018						32			
74	drape, sterile, for mayo stand	SB012						1			
75	film, x-ray laser print	SK098								3	
76	computer media, dvd	SK013								1	
77	X-ray envelope	SK0191								1	
78											
79	Equipment										
80	accelerator, 6-18 MV	ER010		60							
81	collimator, multileaf system w-autocrane (MIMiC)	ER017		60							
82	camera, digital (6 megapixel)	ED004		5							
83	portal imaging system (w-PC work station and software)	ER070			24						
84	Ultrasound unit, shimadzu	EQ250						22			
85	film alternator	E9029								4	
86	film processor, dry laser	ED024								4	
87	room, CT	EL007								18	



October 1, 2010

Carol Bazell  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Mail Stop C4-01-26  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Dear Ms. Bazell:

In the 2011 proposed Medicare Physician Fee Schedule (MPFS), page 40063, the Centers for Medicare and Medicaid Services (CMS) identified the fiducial screws (CMS Supply Code SD073) as a high-cost supply item and requested the RUC to review this practice expense input with respect to their inclusion as practice expense inputs within CPT codes *77301 Intensity modulated radiotherapy plan, including dose volume histograms for target and critical structure partial tolerance specifications* and *77011 Computed tomography guidance for stereotactic localization*.

The American Medical Association/Specialty Society RVS Update Committee (RUC) convened September 30 through October 3, 2010. At this meeting, the RUC's Practice Expense Subcommittee met and discussed the CMS request. After review of the practice expense inputs for CPT code 77011, the RUC's Practice Expense Subcommittee and the RUC agreed that the fiducial screws are not considered typical for this procedure and therefore can be removed from the code's supply list. In addition, fiducial screws should be removed from the list of supplies as a recent CMS transmittal this year (effective as of November 6th 2010) (<https://www.cms.gov/transmittals/downloads/R745OTN.pdf>) clearly instructs Medicare payers to reimburse fiducial markers with HCPCS code A4648 as a separately billable item when used with CPT codes for the insertion of fiducial markers for IMRT (ie., 77301).

The RUC therefore recommends that fiducial screws (SD073) be removed from the list of practice expense inputs for CPT codes 77011 and 77301.

We appreciate the opportunity to provide input on this important issue. Should you have any questions or concerns regarding this matter please contact RUC staff member, Todd Klemp, at [Todd.Klemp@ama-assn.org](mailto:Todd.Klemp@ama-assn.org) or 312-464-4720.

Sincerely,

A handwritten signature in black ink, appearing to read "Barbara Levy, MD". The signature is fluid and cursive, with "Barbara" and "Levy" being more distinct and "MD" being smaller and placed to the right.

Barbara Levy, MD  
Chair, AMA/Specialty Society RVS Update Committee

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
*Originated through the Harvard Valued - Utilization over 100,000 Screen*  
October 2010

## Cytopathology

In October 2009, CPT code 88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation* was identified through the RUC Relativity Assessment Workgroup as a service based on Harvard times that had utilization over 100,000 and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted. CPT codes 88106-88108 were identified as part of the Cytopathology family. Upon subsequent review, the specialty society recommended that CPT code 88107 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears and simple filter preparation with interpretation* be deleted as this service is no longer in widespread clinical use.

### **88104 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation***

The RUC reviewed the survey results from 88 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 24 minutes based on the survey results. The RUC compared the service to key reference CPT code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU=1.18). The specialty society and the RUC noted that the data supplied by the survey respondents over-estimates the work associated with this service as demonstrated in the inappropriate key reference code selected by the survey respondents which has substantial pre-service and post-service time while the surveyed code has no pre-service or post-service time. Although the RUC agreed that the surveyed code overall is a more intense service to perform in comparison to the reference code, the RUC noted that the surveyed code requires 19 less minutes to perform in comparison to the reference code. The RUC agreed that a better reference code to compare the surveyed code to is 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (work RVU=0.52). The RUC noted that the surveyed code has more intra-service time as compared to this reference code, 24 minutes and 20 minutes, respectively. Based on these comparisons and that the specialty had no compelling evidence to change the current value of the service, the RUC agreed that the survey data supports maintaining the current value of this service. **The RUC recommends a work RVU of 0.56 for CPT code 88104.**

### **88106 *Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation***

The RUC reviewed the survey results from 32 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 16 minutes based on the survey results. The RUC compared the service to key reference CPT code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU=1.18). The specialty society and the RUC noted that the data supplied by the survey respondents over-estimates the work associated with this service as demonstrated in the inappropriate key reference code selected by the survey respondents which has substantial pre-service and post-service time while the surveyed code has no pre-service or post-service time. The RUC noted that the surveyed code requires 27 less minutes to perform in comparison to the reference code. Further, the RUC noted that the reference code overall is a more

intense service to perform in comparison to the surveyed code. The RUC agreed that a better reference code to compare the surveyed code to is 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU=0.62). The RUC noted that the surveyed code has less intra-service time as compared to this reference code, 16 minutes and 20 minutes, respectively.

Further, the RUC discussed the relativity between 88104 and 88106 as the specialty is recommending that they be valued the same despite different times associated with both services. The specialty explained that 88106 utilizes a filter method which utilizes a sample that does not contain much blood and little debris while 88104 is a comparable service but because no filter method has been applied the sample reviewed has more blood and debris in it than the sample reviewed in 88106. This variance in sample explains the differences in times for these services despite the same work value. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports maintaining the current value of this service. **The RUC recommends a work RVU of 0.56 for CPT code 88106.**

#### **88108 Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)**

The RUC reviewed the survey results from 48 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service. The specialty recommended no pre-service or post-service time for this service and an intra-time of 19 minutes based on the survey results. The RUC compared the service to key reference CPT code 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal* (work RVU=1.18). The specialty society and the RUC noted that the data supplied by the survey respondents over-estimates the work associated with this service as demonstrated in the inappropriate key reference code selected by the survey respondents which has substantial pre-service and post-service time while the surveyed code has no pre-service or post-service time. The RUC noted that the surveyed code requires 24 less minutes to perform in comparison to the reference code. Further, the RUC noted that the reference code overall is a more intense service to perform in comparison to the surveyed code. The RUC agreed that a better reference code to compare the surveyed code to is 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (work RVU=0.62). The RUC noted that the surveyed code has less intra-service time as compared to this reference code, 19 minutes and 20 minutes, respectively. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports maintaining the current value of this service. **The RUC recommends a work RVU of 0.56 for CPT code 88108.**

CPT Code	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommen-dation
88104		Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation	XXX	0.56 (No Change)

CPT Code	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommen-dation
88106		<p>Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation</p> <p>(Do not report 88106 in conjunction with 88104)</p>	XXX	<p>0.56 (No Change)</p>
88107		<p><del>Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears and simple filter preparation with interpretation</del></p> <p><u>(88107 has been deleted.)</u></p> <p>To report smears and simple filter preparation, see 88104, 88106)</p> <p>(For nongynecological selective cellular enhancement including filter transfer technique, use 88112)</p>	XXX	<p>Code Deleted for CPT 2012</p>
88108		Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)	XXX	<p>0.56 (No Change)</p>



**cap**

August 24, 2010

Barbara Levy, MD  
Chair, AMA/Specialty Society RVS Update Committee  
American Medical Association  
515 N. State St.  
Chicago, IL 60654

Re: 88104 Code Family, Deletion of 88107

Dear Dr. Levy:

For the April 2010 AMA RUC meeting, the College of American Pathologists (CAP) submitted a letter to the Research Subcommittee indicating that upon review of the 88104 code family (88104-88108), CAP had decided to recommend deleting code 88107 since this service is no longer in widespread clinical use. CAP submitted a code proposal to delete code 88107 for the October 2010 CPT Panel meeting. Work recommendations for the remainder of the 88104 code family have been submitted for the October 2010 RUC meeting.

If you have any questions, please contact Kim Chisolm, Assistant Director of Economic Affairs at (202) 354-7118 or [kchisol@cap.org](mailto:kchisol@cap.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan L. Myles".

Jonathan L. Myles, MD, FCAP  
CAP RUC Advisor

CC: Barbara Levy, MD, RUC Chair  
Susan Spires, MD, RUC Member  
J. Allan Tucker, MD, RUC Alternate Member  
Margaret Havens Neal, MD, ASC RUC Advisor  
Mark Synovec, MD, CPT Member  
Sherry Smith, AMA RUC Staff

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 88104  
Global Period: XXX

Tracking Number

Specialty Society Recommended RVU: **0.56**  
RUC Recommended RVU: **0.56**

CPT Descriptor: Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Bronchoscopic brushings are obtained from a left main stem bronchus mass in a 60 year old male with hemoptysis and a cytologic examination is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

---

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist receives prescreened Wright and Pap and/or H&E stained slides and rescreens the slides. The pathologist identifies clinically meaningful findings and renders an interpretation. The findings are correlated with clinical history, previous cytologic and tissue samples, and laboratory tests. The pathologist composes, dictates, edits, and signs the report and communicates findings to appropriate caregivers.

Description of Post-Service Work: N/A

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	10/2010				
<b>Presenter(s):</b>	Jonathan L. Myles, MD, FCAP, Margaret Havens Neal, MD, FCAP				
<b>Specialty(s):</b>	College of American Pathologists, American Society of Cytopathology				
<b>CPT Code:</b>	88104				
<b>Sample Size:</b>	1000	<b>Resp N:</b>	88	<b>Response:</b> 8.8 %	
<b>Sample Type:</b>	Random	<b>Additional Sample Information:</b>			
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>
<b>Service Performance Rate</b>		5.00	50.00	<b>130.00</b>	463.00
<b>Survey RVW:</b>		0.73	1.00	<b>1.18</b>	1.39
<b>Pre-Service Evaluation Time:</b>				<b>0.00</b>	
<b>Pre-Service Positioning Time:</b>				<b>0.00</b>	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>0.00</b>	
<b>Intra-Service Time:</b>		5.00	15.00	<b>24.00</b>	30.00
<b>Immediate Post Service-Time:</b>		<b>0.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<b>0.00</b>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<b>0.00</b>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:  
XXX Global Code

<b>CPT Code:</b>	88104	<b>Recommended Physician Work RVU: 0.56</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>0.00</b>	<b>0.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>24.00</b>		
<b>Immediate Post Service-Time:</b>		<b>0.00</b>		
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
Critical Care time/visit(s):	<b>0.00</b>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<b>0.00</b>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<b>0.00</b>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<b>0.00</b>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<b>0.00</b>	99354x 0.00	55x 0.00	56x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88112	XXX	1.18	RUC Time

CPT Descriptor Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
99212	XXX	0.48	RUC Time	20,255,798

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	Most Recent
				<u>Medicare Utilization</u>
11056	000	0.61	RUC Time	1,586,212

CPT Descriptor 2 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 44      % of respondents: 50.0 %

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 88104	<u>Key Reference CPT Code:</u> 88112	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	8.00	
Median Intra-Service Time	24.00	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	
Prolonged Services Time	0.0	0.00	

Median Total Time	24.00	43.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

3.80      3.78

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

3.67      3.62

Urgency of medical decision making

3.87      3.73

**Technical Skill/Physical Effort (Mean)**

Technical skill required

4.09      3.91

Physical effort required

3.20      3.11

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

3.87      3.78

Outcome depends on the skill and judgment of physician

4.38      4.29

Estimated risk of malpractice suit with poor outcome

4.22      4.20

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

0.00      0.00

Intra-Service intensity/complexity

3.73      3.69

Post-Service intensity/complexity

0.00      0.00

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. If your society has used an IPUT 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 an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

### **The expert panel recommends the current RVW value of 0.56**

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
- 2) Compared the recommended RVW, time and intensity/complexity of 88104 to the reference service  
*88112 Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vagina*
- 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88104

#### Review of Survey Results

The survey had a response rate of 88 and a survey median time of 24 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 24 minutes compares very favorably with the data from the Hsiao studies at 21 minutes.

Panel members reviewed the recommended RVW from the survey data and indicated that the survey median of 1.18 is somewhat high for this service, and that there is no compelling evidence to increase the current value of 88104. Therefore, no change in value is recommended.

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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.
- 

### **FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88104

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology

How often? Commonly

Specialty	How often?
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**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 the frequency and percentage for each specialty. Please explain the rationale for this estimate.

**Specialty**      **Frequency**      **Percentage**      **%**

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period?  
158,678 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
Please explain the rationale for this estimate. RUC Database 2008 Utilization

**Specialty**                    **Frequency**                    **Percentage**                    **%**

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

## **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88104

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

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CPT Code:88106  
Global Period: XXX

Tracking Number

Specialty Society Recommended RVU: **0.56**  
RUC Recommended RVU: **0.56**

CPT Descriptor: Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Bladder washings are obtained during cystoscopic examination in a 70 year old male with hematuria and a cytologic examination is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

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Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist receives prescreened Pap stained filter preparation and rescreens the slide(s). The pathologist identifies clinically meaningful findings and renders an interpretation. The findings are correlated with clinical history, previous cytologic and tissue samples, and laboratory tests. The pathologist composes, dictates, edits and signs the report and communicates findings to appropriate caregivers.

Description of Post-Service Work: N/A

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Margaret Havens Neal, MD, FCAP				
Specialty(s):	College of American Pathologists, American Society of Cytopathology				
CPT Code:	88106				
Sample Size:	1000	Resp N:	32	Response: 3.2 %	
Sample Type:	Random	Additional Sample Information:			
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>
Service Performance Rate		10.00	25.00	103.00	300.00
Survey RVW:		1.00	1.18	1.18	1.20
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	15.00	16.00	20.00
Immediate Post Service-Time:	<u>0.00</u>				
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:  
XXX Global Code

CPT Code:	88106	Recommended Physician Work RVU: 0.56		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		16.00		
Immediate Post Service-Time:	<u>0.00</u>			
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88112	XXX	1.18	RUC Time

CPT Descriptor Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	20,255,798

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11056	000	0.61	Other	1,586,212

CPT Descriptor 2 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>88106</u>	<u>Key Reference CPT Code:</u> <u>88112</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	0.00	8.00	
Median Intra-Service Time	16.00	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	
Prolonged Services Time	0.0	0.00	

<b>Median Total Time</b>	<b>16.00</b>	<b>43.00</b>
<b>Other time if appropriate</b>		

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.63	3.67
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	3.46
--	------	------

Urgency of medical decision making	3.38	3.33
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.75	3.67
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Physical effort required	3.21	3.13
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.42	3.46
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Outcome depends on the skill and judgment of physician	3.92	3.88
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Estimated risk of malpractice suit with poor outcome	3.63	3.62
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**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.63	3.67
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Post-Service intensity/complexity	0.00	0.00
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**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. If your society has used a 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 an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

### The expert panel recommends the current RVW value of 0.56

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
- 2) Compared the recommended RVW, time and intensity/complexity of 88106 to the reference service 88112 *Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vagina*
- 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88106

#### Review of Survey Results

The survey had a response rate of 32 and a survey median time of 16 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 16 minutes compares favorably with the time data from the RUC database. The panel noted that the time in the RUC database is not surveyed-based but is the result of a crosswalk, while the current survey data and RVW are a more robust evaluation of the actual work for this service.

Panel members reviewed the recommended RVW from the survey data and indicated that the survey median of 1.18 is high for this service. [The current value of 0.56 is appropriate when compared to the key reference service code 88112 with 25 minutes of time and an RVW of 1.18. Half the physician time of 88112 is 12.5 minutes, and half of the RVW of 88112 is 0.59, which compares favorably with the survey median of 13 minutes and the current RVW of code 88106 at 0.56.] There is no compelling evidence to increase the current value of 88106. Therefore, no change in value is recommended.

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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.
- 

### FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88106

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology                    How often? Sometimes

Specialty                            How often?

Specialty                            How often?

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 the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?  
 11,361 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.  
 Please explain the rationale for this estimate. RUC database 2008 Utilization

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88106

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

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CPT Code: 88108  
Global Period: XXX

Tracking Number

Specialty Society Recommended RVU: **0.56**  
RUC Recommended RVU: **0.56**

CPT Descriptor: Cytopathology, concentration technique, smears and interpretation (eg, Saccomanno technique)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A voided urine specimen is obtained from a 72 year old male smoker who has the history of urothelial carcinoma of the bladder and cytologic examination is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;  
Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

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Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist receives prescreened cytospin slide(s) and rescreens the slide(s). The pathologist identifies clinically meaningful findings and renders an interpretation. The findings are correlated with clinical history, previous cytologic and tissue samples, and laboratory tests. The pathologist composes, dictates, edits and signs the report and communicates findings to appropriate caregivers.

Description of Post-Service Work: N/A

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Margaret Havens Neal, MD, FCAP				
Specialty(s):	College of American Pathologists, American Society of Cytopathology				
CPT Code:	88108				
Sample Size:	1000	Resp N:	48	Response: 4.8 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		10.00	50.00	100.00	350.00
Survey RVW:		1.00	1.18	1.18	1.20
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	14.25	19.00	25.00
Immediate Post Service-Time:	0.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	88108	Recommended Physician Work RVU: 0.56		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		19.00		
Immediate Post Service-Time:	0.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88112	XXX	1.18	RUC Time

CPT Descriptor Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	20,255,798

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11056	000	0.61	Other	1,586,212

CPT Descriptor 2 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 75.0 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 88108	<u>Key Reference CPT Code:</u> 88112	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	8.00	
Median Intra-Service Time	19.00	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	
Prolonged Services Time	0.0	0.00	

Median Total Time	19.00	43.00
Other time if appropriate		43.00

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.78	3.83
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.53
--	------	------

Urgency of medical decision making	3.53	3.47
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.86	3.86
--------------------------	------	------

Physical effort required	3.08	3.11
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.61	3.67
---	------	------

Outcome depends on the skill and judgment of physician	4.08	4.08
--	------	------

Estimated risk of malpractice suit with poor outcome	3.75	3.72
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.53	3.69
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. If your society has used a 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 an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

### **The expert panel recommends the current RVW value of 0.56**

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
- 2) Compared the recommended RVW, time and intensity/complexity of 88108 to the reference service  
*88112 Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vagina*
- 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88108

#### Review of Survey Results

The survey had a response rate of 48 and a survey median time of 19 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 19 minutes compares favorably with the time data from the Hsiao studies at 18 minutes.

Panel members reviewed the recommended RVW from the survey data and indicated that the survey median of 1.18 is somewhat high for this service, and that there is no compelling evidence to increase the current value of 88108. Therefore, no change in value is recommended.

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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.
- 

### **FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88108

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology

How often? Commonly

Specialty                    How often?

Specialty                    How often?

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 the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

355,061 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database 2008 Utilization

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88108

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010

Originated from the RUC Relativity Assessment - Harvard Valued - Utilization over 100,000 Screen

**Pathology Consultation During Surgery**

In October 2009, CPT codes 88331 and 88332 were identified by the RUC Relativity Assessment Workgroup as a service based on Harvard time with utilization over 100,000 and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted. CPT code 88329 were identified as part of the 88331-88332 family.

***88329 Pathology consultation during surgery;***

The RUC reviewed the survey results from 82 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 21 minutes based on the survey results. The RUC compared the service to key reference CPT code 88333 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site* (work RVU=1.20). The RUC noted that the surveyed code requires less time to perform in comparison to the reference code, 21 minutes and 25 minutes, respectively. Further, the RUC noted that the reference code overall is a more intense service to perform in comparison to the surveyed code requiring more mental effort and judgment and psychological stress. Further, the RUC compared the surveyed code to MPC code 11056 *Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions* (Work RVU=0.61). The RUC noted that the surveyed code requires more total time to perform than the MPC code, 21 minutes and 15 minutes, respectively. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 0.67 for CPT code 88329.**

***88331 Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen***

The RUC reviewed the survey results from 65 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 25 minutes based on the survey results. The RUC compared the service to key reference CPT code 88333 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site* (work RVU=1.20). The RUC noted that despite the surveyed code requiring more mental effort and judgment technical skill and physical effort to perform, the surveyed code and the reference code have the same intra-service time, 25 minutes. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 1.19 for CPT code 88331.**

**88332 Pathology consultation during surgery; each additional tissue block with frozen section(s)**

The RUC reviewed the survey results from 51 pathologists who frequently perform this service. The specialty recommended no pre-service or post-service time for this service and intra-time of 16 minutes based on the survey results. The RUC compared the service to key reference CPT code 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (work RVU=0.73). The RUC noted that the surveyed code requires less time to perform in comparison to the reference code, 16 minutes and 20 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment to perform in comparison to the surveyed code. In addition, the RUC compared the surveyed code to MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient*, (Work RVU=0.48). The RUC noted that the surveyed code has more intra-service time as compared to the MPC code, 16 minutes and 10 minutes. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports the current value of this service. **The RUC recommends a work RVU of 0.59 for CPT code 88332.**

CPT Code	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommen-dation
88329		Pathology consultation during surgery;	XXX	0.67 (No Change)
88331		first tissue block, with frozen section(s), single specimen	XXX	1.19 (No Change)
88332		each additional tissue block with frozen section(s)	XXX	0.59 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 88329  
Global Period: XXX

Tracking Number

Specialty Society Recommended RVU: **0.67**  
RUC Recommended RVU: **0.67**

CPT Descriptor: Pathology consultation during surgery;

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Gross evaluation of a breast lumpectomy specimen obtained from a 54 year old female to evaluate for presence of a mass and distance from resection margins

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

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Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist receives the specimen and reviews the pertinent clinical information from the surgeon. The pathologist then queries the medical record for the patient's original diagnosis and pertinent radiologic studies. The specimen is grossly examined, maintaining orientation, margins are differentially inked as appropriate, and multiple cross sections are made and evaluated for macroscopic tumor involvement. The pathologist measures distances from tumor to surgical margins. The pathologist formulates an interpretation, presents a verbal report to the surgeon intra-operatively, and records a written confirmation of this report in the patient's medical record.

Description of Post-Service Work: N/A

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	88329				
Sample Size:	2500	Resp N:	82	Response: 3.2 %	
Sample Type:	Random	Additional Sample Information:			
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>
Service Performance Rate		10.00	25.00	50.00	100.00
Survey RVW:		0.45	0.73	1.00	1.20
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		10.00	16.25	21.00	25.00
Immediate Post Service-Time:	<u>0.00</u>				
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:  
XXX Global Code

CPT Code:	88329	Recommended Physician Work RVU: 0.67		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		21.00		
Immediate Post Service-Time:	<u>0.00</u>			
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88333	XXX	1.20	RUC Time

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent</u>
11056	000	0.61	Other	Medicare Utilization 1,586,212

CPT Descriptor 1 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent</u>
20610	000	0.79	RUC Time	Medicare Utilization 5,625,121

CPT Descriptor 2 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 54      % of respondents: 65.8 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>88329</u>	<u>Key Reference CPT Code:</u> <u>88333</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	21.00	25.00	
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	
Prolonged Services Time	0.0	0.00	
Median Total Time	21.00	25.00	
Other time if appropriate			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	3.59	4.11
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.69
--	------	------

Urgency of medical decision making	4.54	4.54
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.07	4.35
--------------------------	------	------

Physical effort required	3.76	3.57
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	4.28
---	------	------

Outcome depends on the skill and judgment of physician	4.39	4.63
--	------	------

Estimated risk of malpractice suit with poor outcome	4.04	4.31
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code**    **Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.80	4.07
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IPUT 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 an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The expert panel recommends the current RVW value of 0.67

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
  - 2) Compared the recommended RVW, time and intensity/complexity of 88329 to the reference service  
*88333 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site*
  - 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88329

### Review of Survey Results

The survey had a response rate of 82 and a survey median time of 21 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 21 minutes compares favorably with the data from the Hsiao studies at 22 minutes.

Panel members reviewed the recommended RVW from the survey data; however, the panel was unable to identify compelling evidence to support an increase in value for this service. Therefore, no change in value is recommended.

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88329

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty              Frequency 0              Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 38,104 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database 2008 Utilization

Specialty              Frequency 0              Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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#### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88329

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 88331  
Global Period: XXX

Tracking Number

Specialty Society Recommended RVU: **1.19**  
RUC Recommended RVU: **1.19**

CPT Descriptor: Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Frozen section assessment of resection margin of a 1.2 cm malignant skin neoplasm removed from the face of a 68 year old female, initial tissue block

Percentage of Survey Respondents who found Vignette to be Typical: 95%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;  
Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

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Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist receives the specimen and reviews the pertinent clinical information from the surgeon. The pathologist then queries the medical record for the patient's original diagnosis. The specimen is examined, maintaining orientation, margins are differentially inked as appropriate, and the specimen is sectioned. Tissue is embedded in medium, frozen, and sectioned in a cryostat. Frozen sections are captured on labeled glass slides. The pathologist then microscopically evaluates all stained slides for clinically meaningful findings and formulates an interpretation. The pathologist presents a verbal report to the surgeon intra-operatively and records a written confirmation of this report in the patient's medical record.

Description of Post-Service Work: N/A

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010					
Presenter(s):	Jonathan L. Myles, MD, FCAP					
Specialty(s):	College of American Pathologists					
CPT Code:	88331					
Sample Size:	2500	Resp N:	65	Response: 2.6 %		
Sample Type:	Random	Additional Sample Information:				
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate		15.00	80.00	100.00	250.00	600.00
Survey RVW:		0.73	1.20	1.20	1.45	1.83
Pre-Service Evaluation Time:				0.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		10.00	20.00	25.00	30.00	40.00
Immediate Post Service-Time:	<u>0.00</u>					
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	88331	Recommended Physician Work RVU: 1.19		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		25.00		
Immediate Post Service-Time:	<u>0.00</u>			
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88333	XXX	1.20	RUC Time

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent</u>
31575	000	1.10	RUC Time	Medicare Utilization 542,548

CPT Descriptor 1 Laryngoscopy, flexible fiberoptic; diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent</u>
74160	XXX	1.27	RUC Time	Medicare Utilization 2,239,673

CPT Descriptor 2 Computed tomography, abdomen; with contrast material(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 56.9 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>88331</u>	<u>Key Reference CPT Code:</u> <u>88333</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	25.00	25.00	
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	
Prolonged Services Time	0.0	0.00	
Median Total Time	25.00	25.00	
Other time if appropriate			

**INTENSITY/COMPLEXITY MEASURES (Mean)****(of those that selected Key Reference code)****Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.59	4.35
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	3.86
--	------	------

Urgency of medical decision making	4.84	4.62
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.73	4.43
--------------------------	------	------

Physical effort required	4.11	3.65
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.62	4.30
---	------	------

Outcome depends on the skill and judgment of physician	4.78	4.65
--	------	------

Estimated risk of malpractice suit with poor outcome	4.41	4.14
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code**    **Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.57	4.41
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

**Additional Rationale and Comments**

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 an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The expert panel recommends the current RVW value of 1.19

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
  - 2) Compared the recommended RVW, time and intensity/complexity of 88331 to the reference service  
*88333 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site*
  - 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88331

## Review of Survey Results

The survey had a response rate of 65 and a survey median time of 25 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 25 minutes compares favorably with the data from the Hsiao studies at 23 minutes.

Panel members reviewed the recommended RVW from the survey data and indicated that the survey median of 1.20 is appropriate; however, the panel was unable to identify compelling evidence to support an increase in value for this service. Therefore, no change in value is recommended.

## 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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88331

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

**Specialty Pathology**      How often? Commonly

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty              Frequency 0              Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 558,374 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC Database 2008 Utilization

Specialty              Frequency 0              Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88331

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:88332  
Global Period: XXX

Tracking Number

Specialty Society Recommended RVU: **0.59**  
RUC Recommended RVU: **0.59**

CPT Descriptor: Pathology consultation during surgery; each additional tissue block with frozen section(s)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Frozen section assessment of resection margin of a 2.5 cm malignant skin neoplasm removed from the back of a 57 year old male, each additional tissue block

Percentage of Survey Respondents who found Vignette to be Typical: 96%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting?

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting?

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

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Description of Pre-Service Work: N/A

Description of Intra-Service Work: An additional margin requires evaluation. The original specimen is further dissected, and additional tissue is embedded in medium and frozen and sectioned in a cryostat. Sections are captured on labeled glass slides. The pathologist then microscopically evaluates all these additional stained slides for clinically meaningful findings and formulates an interpretation. The pathologist presents a verbal report to the surgeon intra-operatively and records a written confirmation of this report in the patient's medical record.

Description of Post-Service Work: N/A

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	88332				
Sample Size:	2500	Resp N:	51	Response: 2.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
<b>Service Performance Rate</b>		10.00	25.00	50.00	100.00
<b>Survey RVW:</b>		0.62	0.73	0.80	1.07
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		8.00	15.00	16.00	20.00
Immediate Post Service-Time:	<u>0.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: XXX Global Code

CPT Code:	88332	Recommended Physician Work RVU: 0.59		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
Pre-Service Positioning Time:		<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
Pre-Service Scrub, Dress, Wait Time:		<u>0.00</u>	<u>0.00</u>	<u>0.00</u>
Intra-Service Time:		<u>16.00</u>		
Immediate Post Service-Time:	<u>0.00</u>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88334	XXX	0.73	RUC Time

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99212	XXX	0.48	RUC Time	20,255,798

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
11056	000	0.61	Other	1,586,212

CPT Descriptor 2 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 35.2 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 88332	<u>Key Reference CPT Code:</u> 88334	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	16.00	20.00	
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	
Prolonged Services Time	0.0	0.00	

Median Total Time	16.00	20.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered	4.33	4.17
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	3.75
--	------	------

Urgency of medical decision making	4.78	4.67
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.50	4.22
--------------------------	------	------

Physical effort required	3.83	3.54
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.33	4.28
---	------	------

Outcome depends on the skill and judgment of physician	4.78	4.61
--	------	------

Estimated risk of malpractice suit with poor outcome	4.28	4.28
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.22	4.00
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

**Additional Rationale and Comments**

Describe the process by which your specialty society reached your final recommendation. If your society has used an IPUT 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 an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

### **The expert panel recommends the current RVW value of 0.59**

The panel took these steps in reaching their conclusion:

- 1) Reviewed the survey results
- 2) Compared the recommended RVW, time and intensity/complexity of 88332 to the reference service  
*88334 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site*
- 3) Compared other services/procedures on the MPC list to the recommended RVW and time of 88332

#### Review of Survey Results

The survey had a response rate of 51 and a survey median time of 16 minutes. The expert panel felt the survey respondents fairly estimated the physician work time. The 16 minutes compares favorably with the data from the Hsiao studies at 15 minutes.

Panel members reviewed the recommended RVW from the survey data, and while the panel did feel the survey median of 0.80 is appropriate, no compelling evidence was identified to support an increase in value for this service. Therefore, no change in value is recommended.

### **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.
- 

### **FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88332

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pathology

How often? Commonly

Specialty

How often?

Specialty                      How often?

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 the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

176,636 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. RUC Database 2008 Utilization

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88332

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
Originated from the RUC Relativity Assessment - Harvard Valued - Utilization over 100,000 Screen

October 2010

**Cardioversion**

In October 2009, CPT code 92960 *Cardioversion, elective, electrical conversion of arrhythmia; external* was identified through the RUC Relativity Assessment Workgroup as a service based on Harvard time with utilization over 100,000 and had never been surveyed by the RUC. The RUC recommended a full RUC survey be conducted.

The RUC reviewed the survey results from 32 cardiologists and electrophysiologists who frequently perform this service. The specialty recommended 21 minutes of pre-service time, 15 minutes of intra-service time and 15 minutes of post-service time based on survey data and standards. The RUC compared the service to key reference CPT code 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU=4.50). The RUC noted that the surveyed code requires less time to perform in comparison to the reference code, 51 minutes and 70 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment and psychological stress to perform in comparison to the surveyed code. Although the survey respondents selected this service as the key reference service, the RUC found other stronger points of comparison, including 99253 *Inpatient consultation for a new or established patient*, (work RVU=2.27). The RUC noted that the surveyed code and the reference code requires similar physician time to perform, 51 minutes and 55 minutes, respectively. Further, the RUC compared the surveyed code to MPC code 52000 *Cystourethroscopy (separate procedure)* (Work RVU=2.23). The RUC noted that the surveyed code and this reference code have the same intra-service time, 15 minutes. Based on these comparisons and that the specialty had no compelling evidence to change the value of the service, the RUC agreed that the survey data supports maintaining the current value of this service, 2.25 RVUs, which is a value between the 25<sup>th</sup> percentile and median of the survey data. **The RUC recommends a work RVU of 2.25 for CPT code 92960.**

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
•92960		Cardioversion, elective, electrical conversion of arrhythmia; external	000	2.25 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code: 92960  
 Global Period: 000

Tracking Number

Specialty Society Recommended RVU: **2.25**  
 RUC Recommended RVU: **2.25**

CPT Descriptor: Cardioversion, elective, electrical conversion of arrhythmia; external

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 75 year old hypertensive female presents with 1 month of dyspnea and palpitations. An electrocardiogram shows atrial fibrillation. She is started on medications to control the heart rate and anti-coagulation with coumadin. After 4 weeks of therapeutic INR levels, she is scheduled for elective outpatient cardioversion.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

**Site of Service (Complete for 010 and 090 Globals Only)**

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

**Moderate Sedation**

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 63%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 28%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:** Review medical records and chart

- Evaluate goals of procedure
- Evaluate for sedation/anesthesia risks
- Review prior cardioversion procedures
- Review current and prior antiarrhythmic therapies and effectiveness

**Description of Intra-Service Work:** Assess new symptoms

- Assess stability of patient for sedation and potential respiratory rescue
- Assess heart rate and rhythm on 12 lead ECG or telemetry
- Answer patient questions for obtaining informed consent
- Supervise insertion or assess adequacy of the IV access
- Supervise ECG electrode application and stability of the monitor signal
- Supervise application of adhesive defibrillation patches or locations for paddle positioning
- Ensure external defibrillator sensing is synchronized to QRS complex and not T wave
- Assess whether additional manual pressure to chest defibrillation patch is required and administer if needed
- Supervise or provide for adequate sedation
- PerformOrder appropriate energy for cardioversion once sedated adequately with appropriate energy

- Ensure cardioversion is synchronized to QRS complex and not T wave
- Assess whether manual pressure to chest is required and administer if needed
- Evaluate rhythm after each cardioversion attempt
- Monitor respiratory status for return to the post sedated state
- Interpret post cardioversion ECG.
- Create or dictate a report for the medical record including whether the procedure was successful or unsuccessful and the resultant rhythm

Description of Post-Service Work: Review, edit, sign report

- Discuss critical abnormal lab values with patient

Review results of cardioversion and any medication changes with the patient and management plans including follow up if indicated

- Discuss with referring physician

Arrange for outpatient clinic follow-up if clinically indicated

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Richard Wright, MD, FACC & R. Christopher Jones, MD, FACC				
Specialty(s):	Cardiology & Electrophysiology				
CPT Code:	92960				
Sample Size:	259	Resp N:	32	Response: 12.3 %	
Sample Type:	Panel	Additional Sample Information: random + panel			
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		8.00	25.00	50.00	63.75
Survey RVW:		0.75	1.75	3.00	4.91
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				5.00	
Pre-Service Scrub, Dress, Wait Time:				7.50	
Intra-Service Time:		5.00	10.00	15.00	16.25
Immediate Post Service-Time:	15.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	0.00	99238x 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process:  
1b-FAC Straightforw Pat Procedure(w sedate/anes)

CPT Code:	92960	Recommended Physician Work RVU: 2.25		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	19.00	-4.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:	15.00			
Immediate Post Service-Time:	15.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	0.00	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	0.00	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99291	XXX	4.50	RUC Time

CPT Descriptor CRITICAL CARE, EVALUATION AND MANAGEMENT OF THE CRITICALLY ILL OR CRITICALLY INJURED PATIENT; FIRST 30-74 MINUTES

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
52000	000	2.23	RUC Time	926,353
<u>CPT Descriptor 1</u> Cystourethroscopy (separate procedure)				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99253	XXX	2.27	RUC Time	3,246,402

CPT Descriptor 2 Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	

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: 18.7 %

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 92960	<u>Key Reference CPT Code:</u> 99291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	21.00	15.00	
Median Intra-Service Time	15.00	40.00	
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	
Prolonged Services Time	0.0	0.00	

Median Total Time	51.00	70.00
Other time if appropriate		

**INTENSITY/COMPLEXITY MEASURES (Mean)**

(of those that selected Key Reference code)

**Mental Effort and Judgment (Mean)**

The number of possible diagnosis and/or the number of management options that must be considered

3.67

4.00

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed

3.83

3.83

Urgency of medical decision making

3.50

4.17

**Technical Skill/Physical Effort (Mean)**

Technical skill required

3.33

3.17

Physical effort required

2.50

2.50

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality

3.67

3.83

Outcome depends on the skill and judgment of physician

3.83

4.17

Estimated risk of malpractice suit with poor outcome

4.33

4.67

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity

3.83

3.50

Intra-Service intensity/complexity

4.50

4.33

Post-Service intensity/complexity

3.83

3.33

**Additional Rationale and Comments**

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 ACC and HRS convened an expert panel of physicians familiar with the service to review the survey results and offer a recommendation to the RUC. Code 92960 is used to report elective external cardioversion and is being reviewed by the

RUC because it has been Harvard valued and has Medicare utilization greater than 100,000. The service was initially scheduled to be reviewed at the April 2010 meeting but was delayed due to the more than 30 codes that were presented by cardiology at that meeting.

The survey was distributed to members of ACC and HRS and included both general cardiologists and electrophysiologists. The panel reviewed the survey work values. They noted that the median work value from the survey was 3.00, higher than the current work value of 2.25. The panel felt that the service had not changed substantially relatively to all other services in the past 20 years and did not believe that the standards of compelling evidence for an increase in work value were met. However, they did believe that the survey amply justified the current work value of 2.25.

The physicians first reviewed the times. Cardioversion is a 0 day global procedure that is performed almost exclusively in the facility setting. The times that had been associated with the service are unreliable because they were not based on survey data but were instead assigned based on Harvard work values. The median survey times showed that for pre-time elements, there was 15 minutes for evaluation, 5 minutes for positioning, and 7.5 minutes for scrub/dress/wait. The physicians on the panel believed that the service most appropriately fit into preservice package 1B, used for straightforward patient and a straightforward procedure with anesthesia in a facility setting. The panel recommended accepting the package inputs with the exception of the evaluation time, which was reduced to 15 minutes so as to not be longer than that reflected on the survey. The panel believed that 15 minutes appropriately represented the intraservice time of this service, though noted that this time was relatively high intensity. The panel thought that the post service time of 15 minutes was also appropriate reflecting extensive discussions about the procedure with the patient and family, as well as discussions about the underlying disease.

As stated above, while the survey median is 3.00 wRVUs, the panel recommended the current work value of 2.25 and believed that the survey supported this position well. The most commonly selected reference code was 99291, used to describe the first hour of critical care. The panel agreed that the service of critical care was more intense than cardioversion, but noted that the current work value for 99291 is 4.5 wRVUs, exactly twice the work value recommendation but only 20 minutes additional total time. The panel discussed that the patients who receive this procedure are often very ill and that the work can be very intense.

The panel also examined one of the MPC list codes, a level 3 inpatient consultation. Although this service is no longer paid by Medicare, it is an established CPT code with an established value and a service well known to cardiologists and many other physicians. That consultation, which is a midlevel hospital consultation, has a total time of 55 minutes, similar to the total time of 51 minutes recommended for cardioversion.

The panel recommended that code 92960 retain a work value of 2.25, with the time inputs as follows: 15 minutes of preservice evaluation time, 1 minute of positioning time, 5 minutes of scrub/dress/wait time, 15 minutes of intraservice time and 15 minutes of post service time.

## 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.

## **FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92960 - existing code on list for review as part of rolling five year review

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 175000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on current Medicare numbers

Specialty Cardiology Frequency 150000 Percentage 85.71 %

**Specialty Internal Medicine**      **Frequency 10000**      **Percentage 5.71%**

Specialty Emergency Medicine      Frequency 10000      Percentage 5.71 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 115,237 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on current Medicare numbers

Specialty Cardiology Frequency 100000 Percentage 86.77 %

Specialty Internal Medicine      Frequency 6000      Percentage 5.20 %

Specialty Emergency Medicine      Frequency 6000      Percentage 5.20 %

Do many physicians perform this service across the United States? Yes

Do many physicians perform this service across the United States? Yes

## **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 92960

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations  
Originated from the RUC Relativity Assessment - Codes Reported Together 75% or More Screen

October 2010

**Chemotherapy Administration – Practice Expense Only**

In April 2010, the following services were identified through the Relativity Assessment Workgroup's Codes Reported 75% or More Together Screen: 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* and 96416 *Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump.*

The Workgroup expressed to the RUC their concerns about potential duplication in resources utilized to perform the service. The specialties acknowledged that there is duplication in the PE pre-service time in the greet patient and change gown activities when multiple services are provided on the same date of service. The specialties explained that the services are done sequentially with separate protocols and contain no physician time duplication, so only practice costs should be addressed. Therefore, the Workgroup recommended a PE review at the October 2010 PE Subcommittee meeting.

In October 2010 the RUC carefully reviewed the typical clinical labor, medial supplies, and equipment recommended by the specialty society for codes 96413 and 96416. The RUC made a few edits and changes and agreed with the modified specialty recommendations. **The RUC recommends the attached direct practice expense inputs for CPT codes 96413 and 96416.**

CPT Code	CPT Descriptor	Global Period	RUC Recommendation
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	XXX	Direct Practice Expense Inputs
96416	initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	XXX	Direct Practice Expense Inputs

	A	B	C	D	E	F
1	<b>AMA Specialty Society RVS Update Committee Recommendation</b>					
2			H15		H17	
3		CPT code	96413		96416	
4	<b>September/October 2010 Meeting</b>	CMS Staff Type and Code	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump			
5	<b>LOCATION</b>		In Office	Out Office	In Office	Out Office
6	<b>GLOBAL PERIOD</b>	RN/OCN	XXX		XXX	
7	<b>TOTAL CLINICAL LABOR TIME</b>	L056A	98		105	
8	<b>Total Pre-time</b>	L056A	6		5	
9	<b>Total Intra-time</b>	L056A	86		94	
10	<b>Total Post-time</b>	L056A	6		6	
11	<b>PRE-SERVICE</b>					
12	<b>Start: Following visit when decision for surgery or procedure made</b>					
13	Complete pre-service diagnostic & referral forms	L056A	3			
14	Coordinate pre-surgery services	L056A	3			
15	Office visit before surgery/procedure: Review test and exam results					
16	Provide pre-service education/obtain consent					
17	Follow-up phone calls & prescriptions					
	Other Clinical Activity, documentation and phone					
18	calls involved with arranging delivery and receipt of the infusion pump	L056A			5	
19	<b>End: When patient enters office for surgery/procedure</b>					
20	<b>SERVICE/PERIOD</b>					
21	<b>Start: When patient enters office for surgery/procedure</b>					
22	<b>Pre-service services</b>					
23	Review charts by chemo nurse regarding course of treatment & obtain chemotherapy-related medical hx	L056A	4		4	
24	Greet patient and provide gowning	L056A	2			
25	Obtain vital signs	L056A	3		3	
26	Provide pre-service education/obtain consent (initial education of 1 hr amortized over average of 6 cycles)	L056A	8		8	
27	Prepare room, equipment,supplies	L056A	2		2	
28	Prepare and position patient and mix chemotherapy	L056A	2		2	
29	Mix chemotherapy	L056A	20		28	
46	Sedate/apply anesthesia					
47	<b>Intra-service</b>					
48	Perform procedure or Assist physician in performing procedure	L056A	27		19	
61	<b>Post-Service</b>					
62	Monitor pt. following service/check tubes, monitors, drains	L056A	5		5	
63	Clean room/equipment by physician staff	L056A	3		3	
64	Complete medical record documentation, diagnostic forms, lab & X-ray requisitions	L056A	5		5	
65	Review/read X-ray, lab, and pathology reports					
66	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions	L056A	5		15	
67	<b>End: Patient leaves office</b>					
68	<b>POST-SERVICE/Period</b>					
69	<b>Start: Patient leaves office</b>					
70	Conduct phone calls/call in prescriptions	L056A	6		6	
79	Conduct phone calls between office visits					
80	Other Activity (please specify)					
81	<b>End: with last office visit before end of global period</b>					

	A	B	C	D	E	F
1	AMA Specialty Society RVS Update Committee Recommendation					
2		H15			H17	
3		CPT code	96413		96416	
4	September/October 2010 Meeting	CMS Staff Type and Code	Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug		Chemotherapy administration, intravenous infusion technique, initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump	
5	LOCATION		In Office	Out Office	In Office	Out Office
82	MEDICAL SUPPLIES					
83	drape, non-sterile, sheet 40in x 60in	SB006	0		1	
84	gloves, non-sterile	SB022	1			
85	gloves, sterile	SB024			1	
86	gloves, non-sterile, nitrile	SB023	0	5	0	
87	gown, staff, impervious	SB027	1		1	
88	cover, thermometer probe	SB004	1		1	
89	swab-pad, alcohol	SJ053	2		3	
90	povidone swabsticks (3 pack uou)	SJ043			1	
91	bandage, strip 0 75in x 3in	SG021	1			
92	needle, 19-25g, butterfly	SC030	1			
93	infusion pump cassette-reservoir	SC013	1		1	
94	iv infusion set	SC018	1			
95	syringe w-needle, OSHA compliant (SafetyGlide)	SC058	3		3	
96	syringe 10-12ml	SC051	1		2	
97	syringe 1ml	SC052	1			
98	syringe 20ml	SC053	1		2	
99	syringe 50-60ml	SC056	1			
100	water, sterile inj	SH075	2			
101	sodium chloride 0 9% inj bacteriostatic (30ml uou)	SH068			1	
102	gauze, non-sterile 2in x 2in	SG050			2	
103	dressing, 4in x 4.75in (Tegaderm)	SG037			1	
104	steri-strip (6 strip uou)	SG074			1	
105	iv tubing (extension)	SC019	1			
106	battery, 9 volt	SK010			2	
107	sodium chloride, 99 0% min.	SL126	1		1	
108	pack, minimum multi-specialty visit	SA048	0		0	
109	graham crackers, 1 packet	SK040	1			
110	juice, apple, 1 oz	SK042	6			
111	cup, drinking	SK018	1			
112	heparin 1,000 units-ml inj	SH039	1		1	
113	Equipment					
114	biohazard hood	EP016	22		31	
115	chair, medical recliner	EF009	83		100	
116	infusion pump	EQ032	83			

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 - RUC Re-Review  
February 2008 - Initial Review

**Excision of Bone-Mandible**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review Code 21025 *Excision of bone (eg, for osteomyelitis or bone abscess); mandible*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 10.03. The specialties enclosed letter explains the mathematical problems and confusion surrounding the CMS proposed “reverse building block” method. The RUC discussed the CMS proposed value of 8.09 and agreed that a value this low would lead to rank order anomalies with other services. The relativity of this service should be maintained and again determined that the service is more work than 29891 *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (Work RVU = 9.67) and slightly less work than 25394 Osteoplasty, carpal bone, shortening (Work RVU = 10.85). A list of other comparable services is listed below in the original RUC recommendations.

**The RUC reaffirms its recommendation of 10.03 for CPT Code 21025.**

**February 2008 RUC Recommendations**

CPT Code 21025 was identified by the RUC’s Five Year Identification Workgroup’s in an effort to address site of service anomalies. The specialty’s original survey data from August 1995 indicated the service was performed in the facility setting whereas recent Medicare Utilization data indicated the service was typically performed in the non-facility setting. The RUC had requested the specialty to resurvey this service.

The specialty agreed with the anomaly although its survey data from 61 oral and maxillofacial surgeons indicated a median length of stay of two days in the hospital (or at least overnight). The specialty society consensus panel recommended to remove all hospital visits and half a day discharge day management to arrive at its recommendation of 11.07 work RVUs.

The RUC reviewed the specialty society survey data and the original recommended work value and obtained a clear explanation of the procedure from the specialty. From the specialty recommendation, the RUC agreed that the pre-service time from the survey respondents was excessive for the service provided. Acknowledging the importance of accurate pre-service time and the new pre-service time standard packages, the RUC adjusted the pre-service time to reflect Pre-Service Time Package 3-Straightforward Patient/Difficult Procedure of 51 minutes with an additional 9 minutes of positioning time for nasotracheal intubation and airway protection.

The RUC agreed that reducing the specialty recommended work relative value by the difference in the pre-service time ( $11.07 - .56 = 10.51$ ) was appropriate. The RUC also agreed that given the Medicare Utilization data for 2006 indicated that the service was provided over 50% of the time in the physician's office, an additional reduction in work RVUs with respect to eliminating the specialty recommended one-half discharge day management was necessary ( $10.51 - .64 = 9.87$ ) to arrive at its final recommended value of 9.87 (*now 10.03 in 2010*).

The RUC also reviewed seven RUC reviewed services with similar physician work, identical intra-service time, and similar post-operative work. The committee reviewed these codes for intra-service work intensities, physician work and time and found that the original specialty work recommendation reflected similarities with these Orthopedic and General Surgery codes. The RUC noted that three of the codes were reviewed by the RUC in the past two years and all since August 2000. In addition, the list contains two multi-specialty points of comparison codes. These seven services are listed below.

38745 *Axillary lymphadenectomy; complete* (Work RVU = 13.71)

49560 *Repair initial incisional or ventral hernia; reducible* (Work RVU = 11.84)

28299 *Correction, hallux valgus (bunion), with or without sesamoideectomy; by double osteotomy* (Work RVU = 11.39)

25608 *Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments* (Work RVU = 10.86)

25394 *Osteoplasty, carpal bone, shortening* (Work RVU = 10.71)

29891 *Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect* (Work RVU = 9.47)

40840 *Vestibuloplasty; anterior* (Work RVU = 9.02)

The RUC compared the physician work of code 21025 to code 29891 and agreed that more time pre-operatively and intra-operatively is necessary for code 21025 for patient airway protection and infection control. The RUC considered the overall physician work for code 21025 to be greater than code 29891. Based on this agreement and the other reference points and adjustments made to the work relative value to reflect the service's typical site of service, the RUC agreed that a work value of 9.87 (*now 10.03 in 2010*) would provide for accurate rank order relativity of this service among procedures with similar work.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	090	<b>10.03</b> <b>(No Change)</b>



**American Association of Oral  
and Maxillofacial Surgeons**

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August 12, 2010

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1503-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

To Whom It May Concern:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) appreciates the opportunity to comment on the Site of Service Anomalies outlined in the 2011 Proposed Medicare Physician Fee Schedule. The AAOMS is specifically interested in commenting on the CMS rationale for adjusting RUC valued codes. Coincidentally, in section “Site of Service Anomalies,” in pages 114-119 CMS utilized code 21025 as an example – a code used by many AAOMS members which was presented to the RUC in 2008.

The AAOMS represents approximately 9,000 U.S. oral and maxillofacial surgeons. The mission of the Association is to provide a means of self-governance relating to professional standards, ethical behavior and responsibilities of its fellows and members; to contribute to the public welfare; to advance the specialty; and to support its fellows and members through education, research and advocacy.

The AAOMS Committee on Healthcare and Advocacy discussed the proposed CMS methodology and rules for assessing codes utilizing the reverse building block methodology. AAOMS cannot support the entire proposed rule, and we strongly urge that the proposal be fully reviewed at the September 2010 RUC meeting, partially due to many questions and confusion surrounding use of IWPUP in valuing services.

In the following discussions page and table references are tied to the CMS-1503-P document. In pages 114-116, CMS reviews its logic as applied to all codes. It then follows with the application of that logic to one code, 21025. Rather than discussing the principles, it is useful to follow this sample provided by CMS.

CMS discussion on page 117 compared the original 21025 code structure and values with changes recommended by the 2008 RUC for CY 2009. The comparisons were easy to follow and consistent with discussion at the referenced RUC meeting and within the “RUC Rationale” section of code 21025 in the 2010 RUC Database. The discussion within the CMS proposed fee schedule was clear because it compared time units to time units. For instance, Pre-Service Time of 75 minutes in the original code value (Table 12) versus 85 minutes subsequently recommended by the RUC for Pre-Service Time (Table 13).

At the 2008 RUC Meeting in which this code was reviewed, AAOMS accepted the reduced Intra-Service time (120 reduced to 90 minutes) and the reduction in Immediate Post-Service Time (43 to 30 minutes). AAOMS also accepted RUC recommended reductions in subsequent visits included in the

global period, from 6 to 4 visits (dismissing two 99231 services while retaining two 99232 and two 99233 visits).

AAOMS concurs with the RUC and CMS's logic of removing post-operative in-patient visit work from the "site of service codes" in general and appreciates and supports retaining or "adding back in"  $\frac{1}{2}$  discharge day work (99238), as the associated work is also accomplished on same day, ASC, and office based patients.

However, in discussing their application of reverse building block methodology, CMS switched from time units to RVUs and IPUT values, which made interpretation of the proposal very difficult to follow.

To help clarify CMS's proposals, the AAOMS Committee on Healthcare & Advocacy (CHCA), plugged the cited values into a series of IPUT Calculators, attached to this letter. Tab 1, titled "Original", contains the values in CMS Table 12. Unfortunately the IPUT values do not match. This may be due to a change in intensity values in calculations prior to 2008 and may in itself illustrate one problem with this type of analysis. Table 12 IPUT = 0.0145, but the IPUT calculated value is 0.01626 (CMS in its discussion rounds to 3 significant digits). AAOMS then calculated new values, using data from Table 13. These are shown on Tab 2, "RUC Recommended." There is a slight difference in the Table 13 IPUT, 0.053, and the calculated value of 0.051.

Subsequent discussion in the CMS proposed fee schedule is difficult to follow, and generates more questions than answers. CMS's rationale was to use the starting (pre-RUC adjusted) RVU of 11.07. Referring to that, Table #14:

The first block, Pre-Service Time, adding 0.22 RVU, is clear enough.  
RUC Recommended Same Day Evaluation Time minus Original Same Day Evaluation Time = 70-60  
= 10 minutes. 10 minutes x Intensity of 0.0224 = +0.22 RVU.

The next block is more difficult to explain. CMS proposes a reduction of -0.44 RVUs saying this was determined using the original IPUT of 0.0145. That value does not match the calculated original IPUT of 0.01626. Further, its relationship to real intra-operative work is not clear. The original intra-op time of 120 was reduced to 90, so the new time is  $\frac{3}{4}$ th of the old time. But calculated Intra-service IPUT changes from 0.016 to 0.051. Where is the value 0.44 obtained? Since IPUT increases as the total global time invested in the code decreases, what is the logic in using the original IPUT in calculating the new value after the work associated from numerous subsequent visits has been removed from the code?

In the Immediate Post-Service Time discussion and Table 14, +0.38 RVU is allocated due to the intra-service time of the eliminated 99231 code. 99231 has a total RVU of 0.76 and one-half of its total time is in the intra-service category, but in its discussion CMS stated that:

"...to be conservative in our deductions of work RVUs associated with the inpatient hospital codes [my bold] from the starting values, we allowed the intra-time of **any inpatient hospital visits** included in the original valuation to migrate to the post-service period of the code."

If CMS really meant to use the plural "any...visits", should they not have included the intra-service time of the other deleted immediate post-service (in-house) code, 99232, a RVU of 0.79? If so, the added RVU would be  $0.38 + 0.79 = 1.07$ . This one change would bring the new proposed value to 8.87, if the other RVU based logic were to be accepted.



If the changes proposed in table 14 are plugged into the IWPUT Calculator (Tab 3; CMS Recommended Changes), the final Intra-Service RVU is 7.92 and the IWPUT is 0.088 if 11.07 is used as the overall RVU. If the total RVU is set at 8.08, the final Intra-Service RVU is 4.93 and the IWPUT is 0.055.

Using IWPUT-based reverse building block analysis to reassess RUC valued codes will create more confusion in an already very complex system, as illustrated by CMS's admission that applying this "... methodology may produce a result that is considerably reduced or, in several cases, a negative value." CMS goes on to assert that some of the problems are likely to be due to codes being over valued originally, stating "We believe in some cases, the starting value, that is, the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services." This may be true, but AAOMS believes that the proposed revaluation, as illustrated in the proposed fee schedule and in the discussion above, will not provide a clear resolution to this problem. Therefore, the AAOMS supports the current relative value and physician time data.

The AAOMS appreciates your consideration of our comments. Should you have questions, please contact Karin Wittich, Associate Executive Director, Practice Management and Governmental Affairs, at (847) 233-4334 or via e-mail at [karinw@aaoms.org](mailto:karinw@aaoms.org).

Sincerely,



Anthony M. Spina, DDS, MD  
Chairman, AAOMS Committee on Healthcare & Advocacy



James M. Startzell, DMD, MS  
AAOMS Advisor to the AMA Relative Value Update Committee

cc: AAOMS Committee on Healthcare and Advocacy  
Robert C. Rinaldi, Ph.D., CAE, AAOMS Executive Director  
Karin K. Wittich, AAOMS Associate Executive Director,  
Practice Management and Government affairs  
Patricia Serpico, AAOMS Manager, Practice Management



## IWPUT Calculator

**FILL IN THE CELLS HIGHLIGHTED IN YELLOW WITH RUC SURVEY DATA. IWPUT WILL BE AUTOCALC'D IN GREEN CELL.**

### **Building Block Method**

**Proposed RVW**

**RVW**

**11.07**

Pre-service	Time	Intensity	(=time x intensity)
Day prior evaluation	0	0.0224	0.00
Same day evaluation	60	0.0224	1.34
Scrub, prep	15	0.0081	0.12
<b>Pre-service total</b>			<b>1.47</b>
Post-service	Time	Intensity	
Immediate post	43	0.0224	0.96
Subsequent visits:	Visit n	E/M RVU	(=n x E/M RVU)
ICU 99291	0.0	4.50	0.00
ICU 99292	0.0	2.25	0.00
99233	0.0	2.00	0.00
99232	1.0	1.39	1.39
99231	1.0	0.76	0.76
Discharge	99238	1.0	1.28
	99239		1.90
			0.00
	99215	0.0	2.11
	99214	0.0	1.50
	99213	2.0	0.97
	99212	2.0	0.48
	99211	2.0	0.18
<b>Post-service total</b>			<b>7.65</b>
<b>Intra-service</b>	<b>Time</b>	<b>IWPUT</b>	
		<b>0.01626</b>	<b>1.95</b>

Tables 15 & 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review																						
CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review
21025 EXCISION OF BONE, LOWER JAW	11.07 2008 10.03 2010	75 1,123	2008 2010	60 1,237	10 40	15 15	75 85	120 90	43 30	2 2	2 2	1 1	1 1	1 1	1 1	1 1	1 1	428 283	0.0145 0.0530	AAOMS	Pre-RUC Evaluation Post-RUC Evaluation	
23415 RELEASE OF SHOULDER LIGAMENT	10.09 2008 9.23 2010	49 1,237	2008 2010	40 1,237	15 15	15 15	49 70	62 60	23 20	3.5 2.0	0.5 0.5	1 1	1 1	1 1	1 1	1 1	1 1	238 247	0.0886 0.0648	AAOS	Pre-RUC Evaluation Post-RUC Evaluation	
25116 REMOVE WRIST/FOREARM LESION	7.38 2009 7.56 2010	36 1,030	2009 2010	40 40	10 10	15 15	36 65	78 60	21 20	15.0 10.0	1.5 3.0	1.5 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	283 249	0.0192 0.0307	ASPS	Pre-RUC Evaluation Post-RUC Evaluation	
27792 TREATMENT OF ANKLE FRACTURE	9.71 2007 9.71 2010	21 6,020	2007 2010	25 40	10 10	15 15	83 65	19 60	4.0 20	2.0 2.0	1.0 1.0	281 259	0.0513 0.0056	AAOS, AOFAS	Pre-RUC Evaluation Post-RUC Evaluation							
28120 PART REMOVAL OF ANKLE/HEEL	5.64 2009 8.27 2010	47 3,851	2009 2010	33 33	10 10	15 15	47 58	67 50	21 20	3.5 3.0	1.5 2.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	280 268	0.0263	AAOS, APMA	Post-RUC Evaluation	
28122 PARTIAL REMOVAL OF FOOT BONE	7.56 2009 7.72 2010	43 10,359	2009 2010	33 33	10 10	15 15	43 58	51 50	26 20	5.0 2.0	1.5 2.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	268 264	0.0304 0.0249	AAOS, APMA	Post-RUC Evaluation	
28725 FUSION OF FOOT BONES	11.97 2009 12.18 2010	50 2,817	2009 2010	45 45	10 10	15 15	50 70	89 90	22 20	4.0 2.0	2.5 3.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	313 339	0.0631 0.0496	AAOS	Pre-RUC Evaluation Post-RUC Evaluation	
28730 FUSION OF FOOT BONES	12.21 2009 12.42 2010	60 1,656	2009 2010	45 45	10 10	15 15	60 70	120 100	20 20	5.0 2.0	1.0 3.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	383 349	0.0331 0.0471	AOFAS, APMA	Pre-RUC Evaluation Post-RUC Evaluation	
28825 PARTIAL AMPUTATION OF TOE	3.71 2008 6.01 2010	17 9,014	2008 2010	25 33	10 10	15 15	42 58	36 30	16 20	3.5 2.0	0.5 2.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	198 224	0.0151 0.0099	ACS, SVS, APMA	Pre-RUC Evaluation Post-RUC Evaluation	
36821 AV FUSION DIRECT ANY SITE	9.15 2008 12.11 2010	29 34,130	2008 2010	25 33	10 10	10 10	54 53	75 90	28 20	2.5 2.0	1.5 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	265 256	0.0540 0.0823	ACS, SVS, RPA	Pre-RUC Evaluation Post-RUC Evaluation	
36825 ARTERY-VEIN AUTOGRAPH	15.13 2010	4,873	2010	40	10	20	70	120	30	1.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation	
42415 EXCISE PARTOID GLAD/LESION	17.99 2009 18.12 2010	55 4,464	2009 2010	55 40	12 12	20 20	55 72	156 150	37 20	3.5 1.0	1.5 2.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	396.5 342	0.0673 0.0843	ACS, AAO-HNS	Pre-RUC Evaluation Post-RUC Evaluation	
42420 EXCISE PARTOID GLAD/LESION	20.87 2009 21.00 2010	57 1,624	2009 2010	57 40	12 12	20 20	57 72	182 180	22 20	3.5 2.0	3.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	439.5 432	0.0687 0.0743	ACS, AAO-HNS	Pre-RUC Evaluation Post-RUC Evaluation	
42440 EXCISE SUBMAXILLARY GLAND	7.05 2009 7.13 2010	47 2,088	2009 2010	47 30	10 10	15 15	47 55	71 60	19 20	1.5 1.0	0.5 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	209 193	0.0500 0.0596	AAO-HNS, ACS	Pre-RUC Evaluation	
49507 PRP I/HERN INIT BLOCK >5 YR	9.97 2009 10.05 2010	45 11,879	2009 2010	45 40	3 20	20	45 63	67.5 70	30 30	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	239.5 260	0.0711 0.0680	ACS	Pre-RUC Evaluation Post-RUC Evaluation	
49521 REREPAIR ING HERNIA, BLOCKED	12.36 2009 12.44 2010	45 2,815	2009 2010	45 40	3 20	20	45 63	90 90	30 30	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	262 279	0.0799	ACS	Pre-RUC Evaluation	
49587 RPR UNBIL-HERN, BLOCK >5 YR	7.96 2009 8.04 2010	45 9,212	2009 2010	45 40	3 20	20	63 60	30 30	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	250 292	0.0459 0.0726	ACS	Pre-RUC Evaluation Post-RUC Evaluation	
49652 LAP VENT/ABD HERNIA REPAIR	12.88 2010	45	2009	15	15	15	75	90	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	292	0.0806	ACS	New Code in 2009	
49653 LAP VENT/ABD HERN PROC COMP	16.21 2010	45	2009	15	15	15	75	120	30	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	378	0.0726	ACS	New Code in 2009	
49654 LAP INC HERNIA REPAIR	15.03 2010	45	2009	15	15	15	75	120	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	362	0.0668	ACS	New Code in 2009	
49655 LAP INC HERN REPAIR,COMP	18.11 2010	50	2009	15	15	15	80	150	30	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	413	0.0700	ACS	New Code in 2009	
52341 CYSTO W/URETER STRICTURE TX	6.11 2008 5.35 2010	47.5 45	2008 2010	45	10	15	47.5 70	45	49 20									156.5	0.0658 0.0789	AUA	Pre-RUC Evaluation Post-RUC Evaluation	
52342 CYSTO W/UP STRICTURE TX	6.61 2008 5.85 2010	60 281	2008 2010	60 40	10 10	10 10	60 60	65 60	30 20			1.0						175	0.0590 0.0700	AUA	Pre-RUC Evaluation Post-RUC Evaluation	
52343 CYSTO W/RENAL STRICTURE TX	7.31 2008 6.65 2010	60 37	2008 2010	60 45	10 10	10 10	60 65	90 60	30 25									200	0.0504 0.0780	AUA	Pre-RUC Evaluation Post-RUC Evaluation	
52344 CYSTO/URETERO, STRICTURE TX	7.81 2008 7.05 2010	60 2,447	2008 2010	60 40	10 10	10 10	60 60	77.5 45	30 20			1.0						187.5	0.0650 0.1200	AUA	Pre-RUC Evaluation Post-RUC Evaluation	
52345 CYSTO/URETERO W/UP STRICTURE	8.31 2008 7.55 2010	50 475	2008 2010	50 45	10 10	15 15	50 70	90 45	30 20			1.0						190	0.0640 0.1277	AUA	Pre-RUC Evaluation Post-RUC Evaluation	
52346 CYSTOURERETO W/RENAL STRICT	9.34 2008 8.58 2010	45 40	2008 2010	45 10	10 10	10 10	45 60	120 60	49 20									135	0.0603 0.0613	AUA	Pre-RUC Evaluation Post-RUC Evaluation	
52400 CYSTOURERETO W/CONGEN REPR	10.06 2008 8.69 2010	90 635	2008 2010	72.5 72.5	10 10	15 15	90 97.5	60 40	30 25			1.0	1.0	1.0	1.0	1.0	1.0	261	0.0727 0.1260	AUA	Pre-RUC Evaluation Post-RUC Evaluation	
52500 REVISION OF BLADDER NECK	9.39 2008 8.14 2010	40 5,348	2008 2010	45 45	10 10	15 15	40 70	45 45	35 27.5			3.0	1.0	1.0	1.0	1.0	1.0	247	0.0613 0.0582	AUA	Pre-RUC Evaluation Post-RUC Evaluation	
52640 RELIEVE BLAD CONTRA	6.69 2008 4.79 2010	50 2,217	2008 2010	50 40	10 10	10 10	50 60	39 30	17 20			2.0	2.0	2.0	2.0	2.0	2.0	216	0.0509 0.0514	AUA	Pre-RUC Evaluation Post-RUC Evaluation	

Tables 15 & 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review																						
CPT Code	Short Descriptor	Last Year Before RUC Review	Work RVU	Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99236	Total Time	IWPUT	Specialty Societies	Review
		2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026		
53445	INSERT URO/VES NCK SPHINCTER	15.21	2009	75				75	126	24		3.0	3.0	1.0	1.0	392	0.0546			Pre-RUC Evaluation		
		15.39	2010	1,949	50	15	20	85	90	25		10	3.0	1.0	1.0	418	0.0572	AUA		Post-RUC Evaluation		
54410	REMOVE/REPLACE PENIS PROSTH	16.48	2008	50				50	145	30		2.0	1.0	1.0		1.0	369	0.0635		Pre-RUC Evaluation		
		15.18	2010	1,328	40	10	15	65	120	30		10	3.0			1.0	338	0.0716	AUA	Post-RUC Evaluation		
54530	REMOVAL OF TESTIS	9.31	2008	58				58	58	17		2.5	0.5		1.0	238.5	0.0673		Pre-RUC Evaluation			
		8.46	2010	1,426	57.5	10	15	82.5	60	30		20	1.0		0.5	246.5	0.0597	AUA	Post-RUC Evaluation			
57287	REVISE/REMOVE SLING REPAIR	11.49	2008	45				45	70	30		10	2.0	2.0		1.0	285	0.0556		Pre-RUC Evaluation		
		11.15	2010	1,795	40	10	10	60	60	20		10	3.0		0.5	1244	0.0912	AUA, ACOG	Post-RUC Evaluation			
61885	INSRT/REDO NEUROSTIM ARRAY	7.37	2009	50				50	60	25		4.0	1.0	1.0	1.0	325	0.0271		Pre-RUC Evaluation			
		6.34	2010	4,356	33	13	15	51	45	20		2.0		0.5	1.0	381	0.0567	AANS/CNS	Post-RUC Evaluation			
62263	EPIDURAL LYSIS MULT SESSIONS	6.41	2009	40				40	30	20		2.0			1.0	200	0.0435		Pre-RUC Evaluation			
		6.54	2010	1,269	33	10	5	48	45	20		10	2.0		0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation			
62350	IMPLANT SPINAL CANAL CATH	8.04	2008	70				70	60	125		4.0		1.0	2.0	1.0	487	-0.0715		Pre-RUC Evaluation		
		6.05	2010	6,416	33	10	5	48	60	20		1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
62355	REMOVE SPINAL CANAL CATHETER	6.60	2008	60				60	40	130		3.0		1.0	2.0	1.0	446	-0.1284		Pre-RUC Evaluation		
		4.35	2010	1,461	33	10	5	48	30	20		1.0			0.5	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
62360	INSERT SPINE INFUSION DEVICE	3.68	2008	60				60	55	123		4.0			2.0	1.0	450	-0.1385		Pre-RUC Evaluation		
		4.33	2010	616	33	10	5	48	60	20		1.0			0.5	170	0.0211	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation			
62361	IMPLANT SPINE INFUSION PUMP	6.59	2008	60				60	60	130		4.0		1.0	2.0	1.0	482	-0.0938		Pre-RUC Evaluation		
		5.65	2010	307	33	10	5	48	60	20		1.0			0.5	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
62362	IMPLANT SPINE INFUSION PUMP	8.58	2008	75				75	90	150		4.0			3.0	1.0	582	-0.0629		Pre-RUC Evaluation		
		6.10	2010	6,570	33	10	5	48	60	20		1.0			0.5	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
62365	REMOVE SPINE INFUSION DEVICE	6.57	2008	60				60	45	125		3.0		1.0	2.0	1.0	446	-0.1123		Pre-RUC Evaluation		
		4.65	2010	1,598	33	10	5	48	45	20		1.0			0.5	155	0.0353	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation			
63650	IMPLANT NEUROELECTRODES	7.57	2008	56				56	74	19		2.0	2.5		1.0	283	0.0152		Pre-RUC Evaluation			
		7.20	2010	31,144	33	10	5	48	60	20		1.0			0.5	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
63685	INSRT/REDO SPINE N GENERATOR	7.87	2008	53				53	62	18		2.0	2.5		1.0	267	0.0245		Pre-RUC Evaluation			
		6.05	2010	9,343	33	10	5	48	60	20		1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
64708	REVISE ARM/LEG NERVE	6.22	2009	46				46	76	18		2.5	0.5		1.0	228	0.0301		Pre-RUC Evaluation			
		6.36	2010	3,069	35	10	10	55	60	15		3.0	1.0		0.5	220	0.0314	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation			
64831	REPAIR OF DIGIT NERVE	10.23	2008	50				50	74	21		2.5	1.0		1.0	260.5	0.0612		Pre-RUC Evaluation			
		9.16	2010	972	40	10	15	65	60	15		2.0	2.0		0.5	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation			
65285	REPAIR OF EYE WOUND	14.43	2009	52				52	79	32		5.5	0.5		1.0	337.5	0.0730		Pre-RUC Evaluation			
		14.71	2010	1,154	37			15	52	79		5.5	0.5		1.0	337.5	0.0766	AAO	Post-RUC Evaluation			

Codes to be reviewed on the Fourth/Five-Year Review Agenda (52640 and 57287) and recent May 2010 Submission (61885)

23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values

\*2010 Post-RUC Review work RVVs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11719 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs)	1 visit (1.28 RVUs)	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	-0.44 RVUs	0.38 RVUs ...	-0.76 RVUs	-1.39 RVUs	-0.64 RVUs	-0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07+0.22 - 0.44+0.38 - 0.76 - 1.39) = 0.64 - 0.36 = 8.08$

The methodology discussed above was applied to each of the site-of-service anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insrt/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insrt/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IWPPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IWPPUT is counterintuitive to the IWPPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2008

**Excision of Bone-Mandible**

Code 21025 *Excision of bone (eg, for osteomyelitis or bone abscess); mandible* was brought under RUC review from the RUC's Five Year Identification Workgroup's efforts to address site of service anomalies. The specialty's original survey data from August 1995 indicated the service was performed in the facility setting whereas recent Medicare Utilization data indicated the service was typically performed in the non-facility setting. RUC had requested the specialty to resurvey this service.

The specialty agreed with the anomaly although its survey data from 61 oral and maxillofacial surgeons indicated a median length of stay of two days in the hospital (or at least overnight). The specialty society consensus panel recommended to remove all hospital visits and half a day discharge day management to arrive at its recommendation of 11.07 work RVUs.

The RUC reviewed the specialty society survey data and original recommended work value and obtained a clear explanation of the procedure from the specialty. From the specialty recommendation, the RUC agreed the pre-service time from the survey respondents was excessive for the service provided. Acknowledging the importance of accurate pre-service time and the new pre-service time standard packages, the RUC adjusted the pre-service time to reflect Pre-Service Time Package 3-Straightforward Patient/Difficult Procedure of 51 minutes with an additional 9 minutes of positioning time for nasotracheal intubation and airway protection.

The RUC agreed that reducing the specialty recommended work relative value by the difference in the pre-service time ( $11.07 - .56 = 10.51$ ) was appropriate. The RUC also agreed that given the Medicare Utilization data for 2006 indicated that the service was provided over 50% of the time in the physician's office, an additional reduction in work RVUs with respect to eliminating the specialty recommended one-half discharge day management was necessary ( $10.51 - .64 = 9.87$ ) to arrive at its final recommended value of 9.87.

The RUC also reviewed seven RUC reviewed services with similar physician work, identical intra-service time, and similar post-operative work. The committee reviewed these codes for intra-service work intensities, physician work and time and found that the original specialty work recommendation reflected similarities with these Orthopedic and General Surgery codes. The RUC noted that three of the codes were reviewed by the RUC in the past two years and all since August 2000. In addition, the list contains two multi-specialty points of comparison codes. These seven services are listed below.

*38745 Axillary lymphadenectomy; complete (Work RVU = 13.71)*

*49560 Repair initial incisional or ventral hernia; reducible (Work RVU = 11.84)*

*28299 Correction, hallux valgus (bunion), with or without sesamoideectomy; by double osteotomy (Work RVU = 11.39)*

*25608 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments (Work RVU = 10.86)*

*25394 Osteoplasty, carpal bone, shortening (Work RVU = 10.71)*

*29891 Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect (Work RVU = 9.47)*

*40840 Vestibuloplasty; anterior (Work RVU = 9.02)*

The RUC compared the physician work of code 21025 to code 29891 and agreed that more time pre-operatively and intra-operatively is necessary for code 21025 for patient airway protection and infection control. The RUC considered the overall physician work for code 21025 to be greater than code 29891. Based on this agreement and the other reference points and adjustments made to the work relative value to reflect the service's typical site of service, the RUC agreed that a work value of 9.87 would provide for accurate rank order relativity of this service among procedures with similar work..

**The RUC recommends a physician work relative value of 9.87 for code 21025.**

**Practice Expense:**

The RUC recommends an adjustment in the direct practice expense inputs for code 21025 to reflect the change in physician time and office visits associated with this service. These changes will be provided separately.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	090	9.87

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:21025      Tracking Number  
 Global Period: 090

Specialty Society Recommended RVU: **11.07**  
 RUC Recommended RVU: **9.87**

CPT Descriptor: Excision of bone (eg, for osteomyelitis or bone abscess); mandible

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 51-year-old woman is to undergo excision of bone for osteomyelitis of the right mandible. She has an approximate 2 year history of recurrent facial swelling, pain and tenderness over the area, and low-grade fever. Prior antibiotic regimens have not consistently abated the problems. Pre-operative imaging yields both radiopaque and radiolucent areas and increased medullary spaces. (Note: If provided, anesthesia other than local is reported separately).

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting?

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Answer patient and family questions and obtain informed consent
- Review pre-operative work-up, including x-rays (e.g., orthopantomograph), CT scans, radioisotope uptake scans and MRIs; the size, extent and location of the affected area are measured, with special notation of the position of the inferior alveolar nerve relative to the borders of the lesion so as to minimize risk of injury.
- Review planned incisions and procedure with emphasis on closure
- Verify that all necessary surgical instruments and supplies are readily available in the operative suite
- Monitor patient positioning and draping, and assist with positioning as needed
- Scrub and gown
- Perform surgical "time out" with operating surgical team
- The site is identified intra-orally and the flap and incision design are decided

Description of Intra-Service Work: Local anesthesia and hemostasis are accomplished with inferior alveolar nerve block and infiltration of the surgical site with adequate time for effect. The posterior oral cavity is draped to prevent aspiration during the procedure. The mucosa overlying the affected area is incised, extending 1cm past the imaged margins. The medial and lateral flaps are elevated and the affected bone is identified. Samples of the tissue are taken for biopsy and for culture for acid fast bacilli, aerobic and anaerobic bacteria. The affected bone is then removed by corticotomy and debridement of the medullary spaces with a combination of hand instrumentation and a roto-osteotome. The inferior alveolar nerve is identified, dissected and protected as indicated. The area is generously lavaged. Intra- and extra-oral drains are placed. Closure is accomplished or the site is packed open as appropriate.

Description of Post-Service Work:

**POSTOPERATIVE WORK, IN FACILITY (if applicable):**

- Review recovery room care and medications with recovery room staff
- The patient is monitored post-operatively for hemostasis
- Consultation with the family and patient regarding the surgery and post-procedure dietary regimen.

- The patient's vital signs are checked.
- The motor and sensory function of are evaluated and recorded.
- Immediate postoperative radiographic study (e.g., orthopantomograph) is obtained and reviewed by the surgeon to determine presence or absence of discontinuity defect.
- C&S ordered, prepared and sent
- Biopsy specimen ordered, prepared and sent
- Additional imaging studies are ordered for comparison with pre-operative evaluation and future comparison for healing assessment.
- Discuss procedure outcome with referring physician
- Dictate procedure outcome and expected recovery letter for referring physician and / or insurance company
- Review instructions for post-discharge wound care and home care with patient and family
- Write orders for post-discharge medications
- Chart patient discharge notes
- Assess adequacy of oral intake before discharge

**POSTOPERATIVE WORK, IN OFFICE:**

- Examine and talk with patient
- Discuss biopsy results with patient
- Assess patients ability to maintain adequate sustenance
- Review any neurology deficit and monitor patients recovery
- Check wound, remove drain when appropriate
- Repack deficit as needed
- Answer patient/family questions
- Answer insurance staff questions
- Discuss patient progress with referring physician
- Write orders for medications
- Discuss progress with patient/family  
Dictate patient progress notes for medical chart
- Dictate procedure outcome letter for referring physician, including plan for dental reconstruction
- Review additional imaging studies for comparison with pre-operative imaging

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Timothy S. Shahbazian, DDS and James M. Startzell, DMD, MS				
Specialty(s):	Oral and Maxillofacial Surgery				
CPT Code:	21025				
Sample Size:	250	Resp N:	61	Response: 24.4 %	
Sample Type:	Random				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate	0.00	2.00	3.00	5.00	20.00
Survey RVW:	4.80	13.90	14.20	19.00	35.00
Pre-Service Evaluation Time:			60.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			15.0		
Intra-Service Time:	35.00	60.00	90.00	120.00	300.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>20.0</u>	99231x 1.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.00	99239x 0.00		
Office time/visit(s):	<u>78.0</u>	99211x 0.0	12x 2.0	13x 2.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	21025				
		<u>Specialty Recommended</u>			
Physician Work RVU:		11.07			
Pre-Service Evaluation Time:		60.0			
Pre-Service Positioning Time:		10.0			
Pre-Service Scrub, Dress, Wait Time:		15.0			
Intra-Service Time:		90.00			
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.0	99239x 0.0		
Office time/visit(s):	<u>78.0</u>	99211x 0.0	12x 2.0	13x 2.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
21046	090	13.97	RUC Time

CPT Descriptor Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (eg, locally aggressive or destructive lesion(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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
28299	090	3,233	11.39		

CPT Descriptor 1 Correction, hallux valgus (bunion), with or without sesamoideectomy; by double osteotomy

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
45190	090	461	10.29		

CPT Descriptor 2 Destruction of rectal tumor (eg, electrodessication, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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)**

	<u>CPT Code:</u> <u>21025</u>	<u>Key Reference CPT Code:</u> <u>21046</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	85.00	75.00	
Median Intra-Service Time	90.00	120.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	20.00	
Median Discharge Day Management Time	0.0	38.00	
Median Office Visit Time	78.0	117.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	283.00	400.00	

Other time if appropriate		
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### 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	3.15	3.57
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.65	3.57
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Urgency of medical decision making	3.42	3.09
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#### Technical Skill/Physical Effort (Mean)

Technical skill required	3.62	3.74
--------------------------	------	------

Physical effort required	3.42	3.30
--------------------------	------	------

#### Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.65	3.52
---	------	------

Outcome depends on the skill and judgment of physician	3.65	3.70
--	------	------

Estimated risk of malpractice suit with poor outcome	3.35	3.35
--	------	------

### INTENSITY/COMPLEXITY MEASURES

CPT Code      Reference  
Service 1

#### Time Segments (Mean)

Pre-Service intensity/complexity	3.37	3.32
----------------------------------	------	------

Intra-Service intensity/complexity	3.52	3.68
------------------------------------	------	------

Post-Service intensity/complexity	3.00	3.08
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### **Additional Rationale**

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

A consensus panel reviewed the survey data for 21025 and concluded that there is no compelling evidence that supports changing the work RVU. The typical patient vignette (correctly) did not define the margins of the abscess or osteomyelitis, therefore a variety of margins may have been considered by survey participants which is demonstrated by the broad range of visits and place of service recommendations. The median LOS of the 61 responses was 2 days in the

hospital (or at least overnight). However, our expert panel believes the typical patient (or a majority of cases) is discharged on the same day. Therefore, we are recommending no hospital visits and  $0.5 \times 99238$  for discharge management. In comparison to the reference code 21046, this procedure would require less intra-operative time because teeth do not need to be removed. Code 21046 is also more likely to require more office visits than 21025 to check wounds and repack weekly, under local anesthesia, until the mandible bone fills the defect. The current work RVU and total physician work for 21025 at 11.07 is correctly less than the key reference code 21046 at 13.97. The current work RVU is also correctly relative to other MPC codes 28299 (work RVU = 11.38) and 45190 (work RVU = 10.29). The intensity of 21025, using the recommended time and visit data results in an IWP/PUT of 0.059 which is more consistent with the physician work required for this procedure. We recommend maintaining the work RVU of 11.07 and the time and visit data as shown above.

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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: 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) Immediate post-operative radiographs are obtained to determine presence or absence of discontinuity defect

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.
- | CPT Code | RVU   | Global | Pre | Intra | Post | Total |
|----------|-------|--------|-----|-------|------|-------|
| 21025    | 11.07 | 090    | 85  | 90    | 30   | 205   |
| 70100    | .18   | XXX    |     |       |      | 5     |
- 

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 21025

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Oral and Maxillofacial Surgery                      How often? Commonly

Specialty Otolaryngology                      How often? Sometimes

Specialty Plastic Surgery                      How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 4500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. consensus panel estimate

Specialty	Frequency	Percentage
	0	0.00 %

Specialty                    Frequency 0                    Percentage 0.00 %

Specialty                    Frequency 0                    Percentage 0.00 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 1,200  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims files

Specialty Oral and Maxillofacial Surgery                    Frequency 955                    Percentage 79.58 %

Specialty Otolaryngology                    Frequency 215                    Percentage 17.91 %

Specialty Plastic Surgery                    Frequency 30                    Percentage 2.50 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 21025 (current code has current PLI)

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
February 2008 – Initial Review

**Shoulder Ligament Release**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT code 23415 *Coracoacromial ligament release, with or without acromioplasty*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 9.23. The specialty's enclosed letter and table of comparison codes emphasize the need to use relativity in reviewing physician work. The specialty also explained that the Harvard study measured post-operative time and did not articulate visits. The visits were extrapolated later for practice expense purposes. The February 2008 survey median was 9.35 and included an estimated 70 minutes of pre-time; 60 minutes intra-time; 20 minutes post-time,  $\frac{1}{2}$  day discharge, and 4 office visits and is similar in work to CPT code 24539 *Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment* (work RVU = 8.98, pre-time = 50 minutes, intra-time = 60, post-time=20,  $\frac{1}{2}$  day discharge and 4 office visits). CPT code 24575 *Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed* (work RVU = 9.71, pre-time = 75 minutes, intra-time = 60, post-time = 30, 1 discharge day and 4 office visits).

**The RUC reaffirms its recommendation of 9.23 for CPT Code 23415.**

**February 2008 RUC Recommendations**

CPT code 23415, *Coracoacromial ligament release, with or without acromioplasty*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU is misvalued, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU were necessary. Based on the

specialty society survey, the RUC agreed that the median time was appropriate. The recommended physician time is, pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 15, intra-service = 60, and immediate post-service = 20. The specialty recommended and the RUC agreed that the reductions in office and hospital visits based on the survey data be adjusted to obtain a new work RVU. The survey data showed that four office visits including two 99212 visits and two 99213 visits were associated with this service. The specialty recommended that the full 99238 discharge day management service be reduced to one-half visit with a reduction in work RVU of 0.64 and the one-half 99231 hospital visit be removed with a reduction in work RVU of 0.38. Subtracting these values from the current work RVU of 10.09 results in a work RVU of 9.07, which the RUC agreed was appropriate and is slightly less than the new survey median.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
23415	Coracoacromial ligament release, with or without acromioplasty	090	9.23 (no change)

August 16, 2010

Barbara Levy, MD  
Chair, AMA/Multi-specialty Relative Value Update (RUC) Committee  
American Medical Association  
515 N. State St.  
Chicago, IL 60610

RE: Tab 62-23415, Shoulder Ligament Release

Dear Dr. Levy,

In the Proposed Rule for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC "re-review" the RUC recommendations for existing CPT codes, originally identified as site-of-service anomalies. The RUC requested that each specialty society prepare a letter and supporting documents explaining why the listed codes are appropriately valued and explain why the methodology described by CMS would not result in a substantially different work RVU from the previously submitted RUC recommendation.

In January of 2008, the American Academy of Orthopaedic Surgery conducted a standard RUC survey for code 23415, Coracoacromial ligament release, with or without acromioplasty and presented the survey results at the January 2008 RUC meeting. This was in response to a "site-of-service" anomaly. We collected 40 total responses and recommended a decrease in work RVU based on these surveys from the previous work RVU of 10.09 to a work RVU of 9.35. Our recommendation was based on magnitude estimation comparing 23415 to the most commonly chosen reference code of 29824. The value of 9.35 represented the survey median value. Our recommendation included an acknowledgement that the site-of-service for this procedure had indeed changed from primarily inpatient to primarily outpatient; we recommended a half-day discharge. At the meeting itself, we further adjusted our recommendation to a value of 9.08 which equaled the previous value minus the work RVUs associated with the previously assigned half hospital visit of 99231 and a half-day discharge. This value was also close to our recommended work RVU of 9.35 and between our median and 25<sup>th</sup>% survey RVWs. It also compared well to our primary reference code of 29824 with similar RVW, total time, the same intra-time, and the same series of post-operative visits for discharge and office visits.

We also presented additional comparison codes and noted that 23415 at 9.08 would maintain rank order with CPT code 23420 also reviewed at the same time. The RUC reviewed the information presented, and by means of magnitude estimation and subtracting the value of the hospital visits, accepted a work RVU of 9.08 with an IWP/UT of 0.065

At this time, we would like to present additional information to support the current work RVU. During the Harvard study of 23415, only estimates for time were captured and then was multiplied by assigned intensities to calculate total work, which was then transformed to work relative value units (i.e. the building block methodology).

We emphasize that Harvard study estimates were for time. The number and level of hospital and/or office visits were imputed by a CMS contractor for purposes of reviewing practice expense

RVUs many years after completion of the Harvard study. Additionally, we also note that for many of the codes, pre- and post-time was predicted using an algorithm that took into account the surveyed intra-service time and the pre- and post-times of an anchor code.

Given this information, it should be clear that work RVUs for visits in current survey data should not be added and/or subtracted from the work RVU for 23415 because time, not visits, was used as building blocks to calculate the initial work RVU.

We disagree with the methodology that CMS describes as "reverse building block" even though it would result in an increase in value for this particular code from the current RVW of 9.23 to 10.63. The methodology described is flawed in that it compares Harvard minutes to imputed E/M visits. The building block for 23415 involved time and assigned intensities followed by technical expert group review and then CMS refinement panels as necessary through magnitude estimation. The RUC's review of 23415, also utilized magnitude estimation to determine whether the current value for the code was supported.

In addition to the key reference code 29824, which is an excellent comparison for 23415, we present a table of codes on the following page that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IWPUT. We believe a review – by magnitude estimation – of this list of procedures adds further support that the current work RVU for 23415, despite the fact that CMS has recommended a higher value, we believe the value arrived at by the RUC is the more correct one and recommend the RUC reaffirm the current value.

Sincerely,

William Creevy, MD  
Advisor, American Academy of Orthopaedic Surgery

CC: RUC 5-Year ID Workgroup

## RUC-Reviewed Comparison Codes to Support the Current Work RVU of Code 23415

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2001 MPC	57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	090	6.87	0.059	181	48			55	20	0.5	1	1
2006	25109	Excision of tendon, forearm and/or wrist, flexor or extensor, each	090	6.94	0.063	191	25	10	15	40	20	0.5	2	1
2005 MPC	49505	Repair initial inguinal hernia, age 5 years or older; reducible	090	7.96	0.065	198	20	15	15	70	20	0.5	1	1
2009	22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	090	8.32	0.050	244	33	3	15	60	20	1	2	1
2008 MPC	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	090	8.60	0.050	223	15	10	5	90	25		2	2
2001	29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)	090	8.98	0.065	225	48			60	20	0.5	2	2
2005	24359	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment	010	8.98	0.083	213	30	10	10	60	20	0.5		4
2008	23415	Coracoacromial ligament release, with or without acromioplasty	090	9.23	0.065	247	40	10	15	60	20	0.5	2	2
2007	24575	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed	090	9.71	0.036	308	45	15	15	60	30	1	3	1
2009	22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	090	10.11	0.050	284	33	3	15	90	30	1	2	1
2009	23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	090	10.13	0.052	285	33	12	15	75	30	1	2	1
2008	23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	090	11.39	0.067	277	40	15	15	90	20	0.5	2	2
2008	23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	090	11.93	0.066	287	40	15	15	100	20	0.5	2	2
2007	23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed;	090	12.30	0.053	338	45	15	15	90	30	1	3	1
2008	23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	090	13.54	0.063	328	45	15	15	120	20	0.5	2	3

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75				75	120	43	2	2	2	1	1	1	1	428	0.0145		Pre-RUC Evaluation	
		10.03	2010	1,123	60	10	15	85	90	30	2	2						283	0.0530	AAOMS	Post-RUC Evaluation	
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49				49	62	23		3.5		0.5		1	1	238	0.0886		Pre-RUC Evaluation	
		9.23	2010	1,237	40	15	15	70	60	20	2.0	2.0					0.5	247	0.0648	AAOS	Post-RUC Evaluation	
		7.38	2009		36			36	78	21	50		1.5		1.0	1.0	1.0	283	0.0192		Pre-RUC Evaluation	
25116	REMOVE WRIST/FOREARM LESION	7.56	2010	1,030	40	10	15	65	60	20	1.0	3.0					0.5	249	0.0307	ASSH, AAOS, ASPS	Post-RUC Evaluation	
		7.91	2007		21	25			83	19		4.0		1.5		1.0						Pre-RUC Evaluation
27792	TREATMENT OF ANKLE FRACTURE	9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0	1.0		1.0	1.0	1.0	281	0.0513	AAOS, AOFAS	Post-RUC Evaluation	
		5.64	2009		47			47	67	21		3.5		1.5		1.0	1.0	259	0.0056		Pre-RUC Evaluation	
28120	PART REMOVAL OF ANKLE/HEEL	8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0	1.0		1.0	1.0	1.0	280	0.0263	AAOS, APMA	Post-RUC Evaluation	
		7.56	2009		43			43	51	26		5.0		1.5		1.0	1.0	268	0.0304		Pre-RUC Evaluation	
28122	PARTIAL REMOVAL OF FOOT BONE	7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0	1.0		1.0	1.0	1.0	264	0.0249	AAOS, APMA	Post-RUC Evaluation	
		11.97	2009		50			50	89	22		4.0		2.5		1.0	1.0	313	0.0631		Pre-RUC Evaluation	
28725	FUSION OF FOOT BONES	12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0		1.0	1.0	1.0	339	0.0496	AAOS	Post-RUC Evaluation	
		12.21	2009		60			60	120			5.0		1.0		1.0	1.0	383	0.0331		Pre-RUC Evaluation	
28730	FUSION OF FOOT BONES	12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0		1.0	1.0	1.0	349	0.0471	AOFAS, APMA	Post-RUC Evaluation	
		3.71	2008		17			25	42	36	16	3.5		0.5		1.0	1.0	198	0.0151		Pre-RUC Evaluation	
28825	PARTIAL AMPUTATION OF TOE	6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0					1.0	224	0.0099	AAOS	Post-RUC Evaluation	
		9.15	2008		29			25	54	75	28	2.5		1.5		1.0	1.0	265	0.0540		Pre-RUC Evaluation	
36821	AV FUSION DIRECT ANY SITE	12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0					1.0	256	0.0823	ACS, SVS, RPA	Post-RUC Evaluation	
		10.00	2009		56			56	81	22		2.5		1.0		1.0	1.0	257	0.0663		Pre-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAFT	15.13	2010	4,873	40	10	20	70	120	30	1.0	2.0	1.0		1.0	1.0	1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation	
		17.99	2009		55			55	156	37		3.5		1.5		1.0	1.0	396.5	0.0671		Pre-RUC Evaluation	
42415	EXCISE PARTOID GLAD/LESION	18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0					1.0	342	0.0843	ACS, AAO-HNS	Post-RUC Evaluation	
		20.87	2009		57			57	182	22		3.5		3.0		1.0	1.0	439.5	0.0687		Pre-RUC Evaluation	
42420	EXCISE PARTOID GLAD/LESION	21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0	1.0	1.0	1.0	1.0	432	0.0743	ACS, AAO-HNS	Post-RUC Evaluation	
		7.05	2009		47			47	71	19		1.5		0.5		1.0	1.0	209	0.0500		Pre-RUC Evaluation	
42440	EXCISE SUBMAXILLARY GLAND	7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0					0.5	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation	
		9.97	2009		45			45	67.5	30	1.0	1.0	1.0		1.0	1.0	1.0	239.5	0.0711		Pre-RUC Evaluation	
49507	PRP I/HERN INIT BLOCK >5 YR	10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0	1.0		1.0	1.0	1.0	260	0.0680	ACS	Post-RUC Evaluation	
		12.36	2009		45			45	90	30	1.0	1.0	1.0		1.0	1.0	1.0	262	0.0799		Pre-RUC Evaluation	
49521	REREPAIR ING HERNIA, BLOCKED	12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0	1.0		1.0	1.0	1.0	280	0.0795	ACS	Post-RUC Evaluation	
		7.96	2009		45			45	60	30	1.0	1.0	1.0		1.0	1.0	1.0	232	0.0465		Pre-RUC Evaluation	
49587	RPR UNBIL HERN, BLOCK >5 YR	8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0	1.0		1.0	1.0	1.0	250	0.0459	ACS	Post-RUC Evaluation	
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010		45	15	15	75	90	30	1.0	1.0	1.0		1.0	1.0	1.0	292	0.0806	ACS	New Code in 2009	
49653	LAP VENT/ABD HERN PROC COMP	16.21	2010		45	15	15	75	120	30	2.0	1.0	1.0		1.0	1.0	1.0	378	0.0726	ACS	New Code in 2009	
49654	LAP INC HERNIA REPAIR	15.03	2010		45	15	15	75	120	30	1.0	1.0	1.0		1.0	1.0	1.0	362	0.0668	ACS	New Code in 2009	
49655	LAP INC HERN REPAIR COMP	18.11	2010		50	15	15	80	150	30	2.0	1.0	1.0		1.0	1.0	1.0	413	0.0700	ACS	New Code in 2009	
		6.11	2008		47.5			47.5	60	49								156.5	0.0658		Pre-RUC Evaluation	
52341	CYSTO W/URETER STRICTURE TX	5.35	2010	2,105	45	10	15	70	45	20								135	0.0789	AUA	Post-RUC Evaluation	
		6.61	2008		60			60	65	30								175	0.0590		Pre-RUC Evaluation	
52342	CYSTO W/UP STRICTURE TX	5.85	2010	281	40	10	10	60	60	20								140	0.0700	AUA	Post-RUC Evaluation	
		7.31	2008		60			60	90	30								200	0.0504		Pre-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	6.55	2010	37	45	10	10	65	60	25								150	0.0780	AUA	Post-RUC Evaluation	
		7.81	2008		60			60	77.5	30								187.5	0.0650		Pre-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.05	2010	2,447	40	10	10	60	45	20								125	0.1200	AUA	Post-RUC Evaluation	
		8.31	2008		50			50	90	30								190	0.0640		Pre-RUC Evaluation	
52345	CYSTO/URETERO W/UP STRICTURE	7.55	2010	475	45	10	15	70	45	20								135	0.1277	AUA	Post-RUC Evaluation	
		9.34	2008		45			45	120	49								214	0.0603		Pre-RUC Evaluation	
52346	CYSTOURERETO W/RENAL STRICT	8.58	2010	144	40	10	10	60	60	20								140	0.1155	AUA	Post-RUC Evaluation	
		10.06	2008		90			90	60	30		1.0	1.0	1.0		1.0	1.0	261	0.0727		Pre-RUC Evaluation	
52400	CYSTOURERETO W/CONGEN REPR	8.69	2010	635	72.5	10	15	97.5	40	25	1.0				0.5	1.0	1.0	197.5	0.1260	AUA	Post-RUC Evaluation	
		9.39	2008		40			40	45	35		3.0		1.0		1.0	1.0	247	0.0613		Pre-RUC Evaluation	
52500	REVISION OF BLADDER NECK	8.14	2010	5,348	45	10	15	70	45	27.5		3.0		3.0		0.5	1.0	230.5	0.0582	AUA	Post-RUC Evaluation	
		6.89	2008		50			50	39	17		2.0		2.0		1.0	1.0	216	0.0509		Pre-RUC Evaluation	
52640	RELIEVE BLAD/CONTRACTURE	4.73	2010	2,217	40	10	10	50	30	20		2.0		2.0		1.0	1.0	161	0.0514	AUA	RUC Evaluation	

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time											Total Time	IWPUT	Specialty Societies	Review				
											1266	1266	1266	1266	1266	1266	1266	1266	1266	1266	1266	1266	1266	1266	1266			
53445	INSERT URO/VES NCK SPHINCTER	15.21	2009	1,949	50	15	20	75	126	24												1.0	392	0.0546	Pre-RUC Evaluation			
		15.39	2010					85	90	25	10	30	10	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	AUA	Post-RUC Evaluation
54410	REMOVE/REPLACE PENIS PROSTH	16.48	2008		50			50	145	30												1.0	369	0.0635	Pre-RUC Evaluation			
		15.18	2010	1,328	40	10	15	65	120	30	10	30	10	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	AUA	Post-RUC Evaluation
54530	REMOVAL OF TESTIS	9.31	2008		58			58	58	17												1.0	238.5	0.0673	Pre-RUC Evaluation			
		8.46	2010	1,426	57.5	10	15	82.5	60	30	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	AUA	Post-RUC Evaluation	
57287	REVISE/REMOVE SLING/REPAIR	11.49	2008		45			45	70	30	10	20	10	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	Pre-RUC Evaluation
		11.15	2010	1,795	40	10	10	60	80	20	10	30	10	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	AUA/ACOG	Post-RUC Evaluation
61885	INSRT/REDO NEUROSTIM ARRAY	7.37	2009		50			50	60	25												1.0	625	0.0271	Pre-RUC Evaluation			
		6.44	2010	4,358	33	3	15	51	45	20											0.5	181	0.0567	AANS/CNS	Post-RUC Evaluation			
62263	EPIDURAL LYSIS MULT SESSIONS	6.41	2009		40			40	30	20											1.0	200	0.0435	Pre-RUC Evaluation				
		6.54	2010	1,269	33	10	5	48	45	20	10	2.0									0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation			
		8.04	2008		70			70	60	125	40									1.0	2.0	1.0	487	-0.0715	Pre-RUC Evaluation			
62350	IMPLANT SPINAL CANAL CATH	6.05	2010	6,416	33	10	5	48	60	20										0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation				
		6.60	2008		60			60	40	130	3.0									1.0	2.0	1.0	446	-0.1284	Pre-RUC Evaluation			
62355	REMOVE SPINAL CANAL CATHETER	4.35	2010	1,461	33	10	5	48	30	20										0.5	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation				
		3.68	2008		60			60	55	123	4.0									2.0	1.0	450	-0.1385	Pre-RUC Evaluation				
62360	INSERT SPINE INFUSION DEVICE	4.33	2010	616	33	10	5	48	60	20										0.5	170	0.0211	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation				
		6.59	2008		60			60	60	130	4.0								1.0	2.0	1.0	482	-0.0938	Pre-RUC Evaluation				
62361	IMPLANT SPINE INFUSION PUMP	5.65	2010	307	33	10	5	48	60	20										0.5	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation				
		8.58	2008		75			75	90	150	4.0									3.0	1.0	582	-0.0629	Pre-RUC Evaluation				
62362	IMPLANT SPINE INFUSION PUMP	6.10	2010	6,570	33	10	5	48	60	20										0.5	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation				
		6.57	2008		60			60	45	125	3.0								1.0	2.0	1.0	446	-0.1123	Pre-RUC Evaluation				
62365	REMOVE SPINE INFUSION DEVICE	4.65	2010	1,598	33	10	5	48	45	20									0.5	155	0.0353	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation					
		7.57	2008		56			56	74	19	2.0									1.0	2.0	1.0	283	0.0152	Pre-RUC Evaluation			
63650	IMPLANT NEUROELECTRODES	7.20	2010	31,144	33	10	5	48	60	20										0.5	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation				
		7.87	2008		53			53	62	18	2.0									1.0	2.0	1.0	267	0.0245	Pre-RUC Evaluation			
63685	INSRT/REDO SPINE N GENERATOR	6.05	2010	9,343	33	10	5	48	60	20										0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation				
		6.22	2009		46			46	76	18	2.5									1.0	2.0	1.0	228	0.0301	Pre-RUC Evaluation			
64708	REVISE ARM/LEG NERVE	6.36	2010	3,069	35	10	10	55	60	15	3.0	1.0								0.5	220	0.0314	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation				
		10.23	2008		50			50	74	21	2.5									1.0	260.5	0.0612	Pre-RUC Evaluation					
64831	REPAIR OF DIGIT NERVE	9.16	2010	972	40	10	15	65	60	15	2.0	2.0								0.5	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation				
		14.43	2009		52			52	79	32	5.5	0.5								1.0	337.5	0.0730	Pre-RUC Evaluation					
65285	REPAIR OF EYE WOUND	14.71	2010	1,154	37			15	52	79	32	5.5	0.5							1.0	337.5	0.0766	AAO	Post-RUC Evaluation				

Codes to be reviewed on the Fourth Five-Year Review Agenda (52640 and 57287) and recent May 2010 Submission (61885)

23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values

\*2010 Post-RUC Review work RVWs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

**c. Codes With High Volume and Low Work RVUs**

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
111719 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

**d. Codes With Site-of-Service Anomalies**

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs)	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	- 0.44 RVUs	0.38 RVUs ...	- 0.76 RVUs	- 1.39 RVUs	- 0.64 RVUs	- 0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39) = 0.64 - 0.36 = 8.08$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insrt/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insrt/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IPUT is counterintuitive to the IPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2008

**Shoulder Ligament Release**

CPT code 23415, *Coracoacromial ligament release, with or without acromioplasty*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated. The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU was incorrect, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU were necessary. Based on the specialty society survey, the RUC agreed that the median time was appropriate. The recommended physician time is, pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 15, intra-service = 60, and immediate post-service = 20. The specialty recommended and the RUC agreed that the reductions in office and hospital visits based on the survey data be adjusted to obtain a new work RVU. The survey data showed that four office visits including two 99212 visits and two 99213 visits were associated with this service. The specialty recommended that the full 99238 discharge day management service be reduced to one-half visit with a reduction in work RVU of 0.64 and the one-half 99231 hospital visit be removed with a reduction in work RVU of 0.38. Subtracting these values from the current work RVU of 10.09 results in a work RVU of 9.07, which the RUC agreed was appropriate and is slightly less than the new survey median. **The RUC recommends a work RVU of 9.07.**

**Practice Expense**

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
23415	Coracoacromial ligament release, with or without acromioplasty	090	9.07

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:23415      Tracking Number  
 Global Period: 090

Specialty Society Recommended RVU: **9.35**  
 RUC Recommended RVU: **9.07**

CPT Descriptor: Coracoacromial ligament release, with or without acromioplasty

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 55-year-old right hand dominant man with a 5 month history of anterior shoulder pain. The pain radiates down the front of the shoulder and is worse at night and with overhead activity. On physical examination, his skin is normal and he has no wasting of his shoulder musculature. He has pain on palpation of the bicipital groove and the greater tuberosity. He has weakness on muscle testing in abduction and external rotation of the shoulder. Tests reveal a Type II acromion and AC joint arthritis as well as impingement and acromioclavicular joint degeneration. Surgery is performed through a deltoid splitting incision.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 35%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 5%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform 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 shoulder is placed on the surgery table. A bolster is placed under the scapula to position the shoulder/clavicle.
- Indicate areas of skin to be prepped and mark surgical incisions
- The arm and shoulder are prepped and draped.
- Scrub and gown
- Perform surgical "time out" with operating surgical team

**Description of Intra-Service Work:**

Under anesthesia, an incision is made over the anterolateral shoulder. The deltoid fibers are split or the deltopectoral interval is developed to expose the coracoacromial (CA) ligament. Once the CA ligament is adequately exposed and hemostasis insured, the ligament is released from the anterior surface of the acromion. That allows exposure of the acromion and at that time an evaluation of the slope of the acromion is made. If the acromion arches significantly the inferior portion of the anterolateral acromion is resected with an oscillating saw or osteotome. If the deltoid muscle

attachment has been disrupted during the exposure, it is repaired. The wound is inspected and irrigated. The wound is closed in layers.

#### Description of Post-Service Work:

##### Post-service work: in facility

- Application of a dressing and sling. Monitor patient during reversal of anesthesia. Assist in transfer of patient from operating table to gurney. Monitor transport of patient from operating room to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Discuss procedure and outcome with family in waiting area. Write brief operative note or complete final operative note and place in chart. Dictate operative report and copy referring physician(s).
- 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.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

##### Post-service work: in office

- Examine and talk with patient
- Answer patient/family questions
- Removal of sling/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)	02/2008					
Presenter(s):	Dale Blasier, MD, FACS; Louis McIntyre, MD					
Specialty(s):	AAOS, AANA					
CPT Code:	23415					
Sample Size:	200	Resp N:	40	Response: 20.0 %		
Sample Type:	Random					
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>	
Service Performance Rate	0.00	0.00	1.00	13.00	120.00	
Survey RVW:	5.00	8.00	9.35	13.00	20.00	
Pre-Service Evaluation Time:			40.0			
Pre-Service Positioning Time:			15.0			
Pre-Service Scrub, Dress, Wait Time:			15.0			
Intra-Service Time:	20.00	39.00	60.00	60.00	120.00	
Immediate Post Service-Time:	<u>20.00</u>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.50	99239x 0.00			
Office time/visit(s):	<u>78.0</u>	99211x 0.0	12x 2.0	13x 2.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38), 99239 (55), 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	23415				
		<u>Specialty Recommended</u>			
Physician Work RVU:					
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			
Immediate Post Service-Time:	<u>0.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29824	090	8.82	RUC Time

CPT Descriptor Arthroscopy, shoulder, surgical; distal claviclelectomy including distal articular surface (Mumford 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
30520	090	19,726	6.85		
<u>CPT Descriptor 1</u> Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft					
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
49505	090	104,825	7.88		

CPT Descriptor 2 Repair initial inguinal hernia, age 5 years or older; reducible

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
<u>CPT Descriptor</u>			

**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: 32.5 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 23415	<u>Key Reference CPT Code:</u> <u>29824</u>	<u>Source of Time</u> RUC Time
Median Pre-Service Time	70.00	48.00	
Median Intra-Service Time	60.00	60.00	
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	19.0	19.00	
Median Office Visit Time	78.0	78.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	247.00	225.00	

Other time if appropriate		
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**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	3.31	3.25
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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	2.54	2.50
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.08	3.92
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Physical effort required	2.92	3.17
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.15	3.00
---	------	------

Outcome depends on the skill and judgment of physician	3.62	3.75
--	------	------

Estimated risk of malpractice suit with poor outcome	2.69	2.75
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**INTENSITY/COMPLEXITY MEASURES**

<u>CPT Code</u>	<u>Reference</u>
Service 1	

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.92	3.00
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Intra-Service intensity/complexity	3.31	3.50
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Post-Service intensity/complexity	2.77	2.92
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**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.

Current data for 23415 is based on a Harvard survey of orthopaedic surgeons. Pre and post work was predicted by algorithm. The number and level of post-operative visits were developed by a CMS contractor for the sole purpose of developing resource-based practice expense RVUs. The contractor did not conduct a survey, but instead used an algorithm. The current Harvard-based RVW (10.09) and Harvard data result in an IWPUT = 0.090.

Our expert consensus panel agrees with the median survey data that indicates the typical patient is discharged from a facility on the day of the procedure. This however does not mean that the post-operative office visits will remain unchanged. The physician work that would have been provided in the facility, now has to be provided in the office. The current RVW and survey data result in an IPUT = 0.082. The survey median RVW and survey data result in an IPUT = 0.069. The consensus panel recognizes that the survey respondents believed 23415 was just slightly more total physician work than the key reference code 29824. Therefore, we recommend the survey median RVW of 9.35 (which is lower than the current value) and the survey median time and visit data for this procedure. This value retains relativity to the key reference code (23415 > 29824) and to another shoulder code being reviewed (23415 > 23120). We also offer two MPC codes (30520 and 49505) with slightly lower and slightly higher RVWs..

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 23415

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery      How often? Sometimes

Specialty How often? Sometimes

**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 the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,432  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty orthopaedic surgery	Frequency 1386	Percentage 96.78 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Current PLI for 23415

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
April 2008 – Initial Review

**Forearm Excision**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT code 25116 *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 7.56. The specialties enclosed letter and table of comparison codes emphasize the need to use relativity in reviewing physician work. The specialty also explained that the Harvard study measured post-operative time and did not articulate visits. The visits were extrapolated later for practice expense purposes. The RUC notes that the specialty survey actually supported a higher work RVU (median = 9.89), however compelling evidence was not presented in April 2008. The survey times for 25116 are 65 minutes of pre-time, 60 minutes intra-time, 20 minutes post-time,  $\frac{1}{2}$  day discharge day management and 4 office visits. CPT code 25116 is similar in work to 24076 *Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm* (work RVU = 7.41, pre-time = 68 minutes; intra-time = 60 minutes, post-time=20 minutes,  $\frac{1}{2}$  day discharge day and 3 office visits) and 46261 *Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy* (work RVU = 7.76, pre-time = 60 minutes; intra-time = 70 minutes; post-time = 30 minutes,  $\frac{1}{2}$  day discharge and 3 office visits).

The RUC also reviewed a table of codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IPUT. This review using magnitude estimation comparison of work RVUs further supports the current work RVU for 25116.

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2001 MPC	57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	090	6.87	0.059	181	48			55	20	0.5	1	1
2009	26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand;	090	6.90	0.041	222	33	9	15	60	15	0.5	1	3

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
		without free graft, each tendon												
2005	27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	090	6.91	0.042	225	33	23	15	60	20	0.5	1	2
2006	25109	Excision of tendon, forearm and/or wrist, flexor or extensor, each	090	6.94	0.063	191	25	10	15	40	20	0.5	2	1
2000	38520	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	090	7.03	0.054	193	45			60	30	0.5	1	1
2008	25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	090	7.13	0.042	221	33	12	15	60	20	0.5	2	1
2005	24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	090	7.41	0.043	229	33	20	15	60	20	0.5	2	1
2008	25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	090	7.56	0.031	249	40	10	15	60	20	0.5	3	1
2000	46261	Hemorrhoidectomy, internal and external, 2 or more columns/groups, with fissurectomy	090	7.76	0.038	241	60			70	30	0.5	2	1
2000	46288	Closure of anal fistula with rectal advancement flap	090	7.81	0.042	236	60			65	30	0.5	2	1
2005	57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	090	7.82	0.064	202	15	15	15	60	20	1.0	1	1
2001	24332	Tenolysis, triceps	090	7.91	0.051	230	50			60	30	0.5	1	3
2007	26665	Open treatment of CMC fracture dislocation, thumb (Bennett fracture), incl internal fix, when performed	090	7.94	0.047	237	35	10	15	60	20	0.5	2	2
2005 MPC	49505	Repair initial inguinal hernia, age 5 years or older; reducible	090	7.96	0.065	198	20	15	15	70	20	0.5	1	1
2001	25652	Open treatment of ulnar styloid fracture	090	8.06	0.056	225	50			60	25	0.5	1	3
2008	25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	090	8.08	0.056	235	40	10	15	60	20	0.5	1	3
2006	25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	8.31	0.042	260	40	10	15	45	30	0.5	3	2
2007	24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process(es)), includes internal fixation, when performed	090	8.37	0.047	252	40	15	10	60	30	0.5	2	2

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

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2008 MPC	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	090	8.60	0.050	223	15	10	5	90	25		2	2

The RUC reaffirms its recommendation of 7.56 for CPT Code 25116.

#### April 2008 RUC Recommendations

CPT code 25116, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicates that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society agreed that there was no compelling evidence to recommend a higher work RVU than is currently assigned to 25116. However, the specialty society noted that current data for 25116 is based on a Harvard survey for intra-service time only and the post-op visits in the database were predicted by CMS using an algorithm rather than a survey. While the specialty society agreed that there was no compelling evidence to increase the value of the service, they also agreed that there was no evidence that the service is misvalued. The specialty society conducted a survey of 55 orthopaedic surgeons to validate physician work, physician time components, and post-operative office visits. The survey resulted in a median pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes, pre-service scrub, dress and wait time of 15 minutes, intra-service time of 60 minutes, and immediate post-service time of 20 minutes. The survey respondents also indicated that the outpatient procedure includes one-half 99238 discharge management service, one 99212 office visit, and three 99213 office visits within its 090 day global period. Further, the survey resulted in a median work RVU of 9.89 and 25<sup>th</sup> percentile work RVU of 9.08. Sixty-nine percent of survey respondents indicated the key reference service 25115, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors, (work RVU = 9.89, intra-service time = 90 minutes)*. The key reference service requires greater intra-service time and, therefore, the RUC agreed that it should be valued slightly higher than the surveyed code. Further supporting the current work RVU for 25116, the calculated intra-service work

per unit of time (IWPUT) with the surveyed times and post-operative visits is 0.031, which is lower than the key reference service IWPUT of 0.050. The RUC concluded that the incremental difference in IWPUT between the survey code and reference code and the difference between the current work RVU of 25116 and 25115 are appropriate to maintain proper rank order between the services.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	090	7.56 (No Change)

August 16, 2010

Barbara Levy, MD  
Chair, AMA/Multi-specialty Relative Value Update (RUC) Committee  
American Medical Association  
515 N. State St.  
Chicago, IL 60610

RE: Tab 63- 25116 Remove wrist / forearm lesion

Dear Dr. Levy,

In the Proposed Rule for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC "re-review" the RUC recommendations for existing CPT codes, originally identified as site-of-service anomalies. The RUC requested that each specialty society prepare a letter and supporting documents explaining why the listed codes are appropriately valued and explain why the methodology described by CMS would not result in a substantially different work RVU from the previously submitted RUC recommendation.

In April 2008, the American Academy of Orthopaedic Surgery, the American Society for Surgery of the Hand, and the American Society of Plastic Surgeons indicated that although the survey data from 55 orthopaedic surgeons, hand surgeons, and plastic surgeons suggested the code was undervalued, we did not believe there was compelling evidence of change in patient or technology to recommend an increase for code 25116. Further, we pointed out the then current RVW (7.38) and Harvard data resulted in a low IWP/PUT = 0.020. The then current RVW (7.38) and the survey data also result in a low IWP/PUT = 0.031. These intensities were and are inconsistent with the intra-operative work of a procedure performed under anesthesia that has a risk of immediate tendon, artery, and/or nerve injury. However, this alone is not compelling evidence. We also noted that if a surgeon spent the total time for 25116 (249 min) performing 99213 E/M services (23 minutes), then the total RVWs would be 35% or 2.58 RVUs greater. [(249 min for 25116) / (23 min for 99213) x (0.92 RVUs for 99213) = 9.96 RVUs]. However, this is also not compelling evidence to increase the work RVU for a code.

Without compelling evidence, we proceeded to present information to support the then current work RVU using a RUC-reviewed reference code that is a very similar procedure as well as additional comparison codes. The RUC reviewed the information presented, and by means of magnitude estimation, concluded the current work RVU was justified.

At this time, we would like to present additional information to support the current work RVU. During the Harvard study of 25116, only estimates for time were captured, as shown in the table below. Time was multiplied by assigned intensities to calculate total work, which was then transformed to work relative value units (ie, the building block methodology, as use by Harvard).

CPT	EVAL	POSIT	SDW	INTRA	IMM-SD	HOSP	OFF
25116	21	0	25	78	21	24	47

We emphasize that Harvard study estimates were for time. Number and level of hospital and/or office visits were imputed by a CMS contractor for purposes of reviewing practice expense RVUs many years after completion of the Harvard study. Additionally, we also note that for many of the codes, pre- and post-time was predicted using an algorithm that took into account the surveyed intra-service time and the pre- and post-times of an anchor code.

Of importance for 25116 is the fact that the estimated 24 minutes of hospital time were transformed to  $1.5 \times 99231$  and  $1.0 \times 99238$  and the estimated 47 minutes of office time were transformed to  $5 \times 99212$ . Given this information, it should be clear that work RVUs for visits in current survey data should not be added and/or subtracted from the work RVU for 25116 because time, not visits, was used as building blocks to calculate the initial work RVU.

We disagree with the methodology that CMS describes as "reverse building block." The methodology described is flawed in that it compares apples (Harvard minutes) to oranges (imputed E/M visits). It is no wonder that the Agency's calculations for some codes result in negative work, since the Agency was mixing data elements incorrectly. The building block for 25116 involved time and assigned intensities followed by technical expert group review and then CMS refinement panels as necessary through magnitude estimation. The RUC's review of 25116 also utilized magnitude estimation to determine whether the current value for the code was supported.

The Agency's flawed methodology results in a difference of (-0.17) work RVUs for 25116. For 20 years, peer-review and CMS refinement of codes has never resulted in such a minor incremental adjustment based on a calculation. Given the information above with respect to Harvard time estimates and current survey estimates, the differential between Harvard total time of 216 minutes versus survey total time of 249 minutes would normally warrant an increase. However, as participants of the RUC review process, we believe magnitude estimation is a more valid methodology than reverse building block, and we continue to support the RUC's previous recommendation to maintain the current value for 25116.

In addition to the key reference code 25115, which is an excellent comparison for 25116, we present a table of codes on the following page that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IWP/PUT. We believe a review – by magnitude estimation – of this list of procedures adds further support that the current work RVU for 25116 is not over-valued, as CMS suggests.

Sincerely,

William Creevy, MD  
Advisor, American Academy of Orthopaedic Surgery

Daniel Nagle, MD  
Advisor, American Society for Surgery of the Hand

Martha Mathews, MD  
Advisor, American Society of Plastic Surgeons

**RUC-Reviewed Comparison Codes to Support the Current Work RVU of Code 25116**

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	S,d,w		sd-im	99238	99213	99212
2001 MPC	57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	090	6.87	0.059	181	48			55	20	0.5	1	1
2009	26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	090	6.90	0.041	222	33	9	15	60	15	0.5	1	3
2005	27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	090	6.91	0.042	225	33	23	15	60	20	0.5	1	2
2006	25109	Excision of tendon, forearm and/or wrist, flexor or extensor, each	090	6.94	0.063	191	25	10	15	40	20	0.5	2	1
2000	38520	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	090	7.03	0.054	193	45			60	30	0.5	1	1
2008	25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	090	7.13	0.042	221	33	12	15	60	20	0.5	2	1
2005	24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	090	7.41	0.043	229	33	20	15	60	20	0.5	2	1
2008	25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	090	7.56	0.031	249	40	10	15	60	20	0.5	3	1
2000	46261	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy	090	7.76	0.038	241	60			70	30	0.5	2	1
2000	46288	Closure of anal fistula with rectal advancement flap	090	7.81	0.042	236	60			65	30	0.5	2	1
2005	57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	090	7.82	0.064	202	15	15	15	60	20	1.0	1	1
2001	24332	Tenolysis, triceps	090	7.91	0.051	230	50			60	30	0.5	1	3
2007	26665	Open treatment of CMC fracture dislocation, thumb (Bennett fracture), incl. internal fix, when performed	090	7.94	0.047	237	35	10	15	60	20	0.5	2	2
2005 MPC	49505	Repair initial inguinal hernia, age 5 years or older; reducible	090	7.96	0.065	198	20	15	15	70	20	0.5	1	1
2001	25652	Open treatment of ulnar styloid fracture	090	8.06	0.056	225	50			60	25	0.5	1	3
2008	25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single, each tendon	090	8.08	0.056	235	40	10	15	60	20	0.5	1	3
2006	25606	Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation	090	8.31	0.042	260	40	10	15	45	30	0.5	3	2
2007	24685	Open treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process(es)), includes internal fixation, when performed	090	8.37	0.047	252	40	15	10	60	30	0.5	2	2
2008 MPC	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	090	8.60	0.050	223	15	10	5	90	25		2	2

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75	75	10	15	75	120	43	2	2	2	1	1	1	1	428	0.0145	Pre-RUC Evaluation		
		10.03	2010	1,123	60			85	90	30		2	2						283	0.0530	AAOMS	Post-RUC Evaluation
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49	49			49	62	23	3.5			0.5		1	1	238	0.0886	Pre-RUC Evaluation		
		9.23	2010	1,237	40	15	15	70	60	20	2.0	2.0						0.5	247	0.0648	AAOS	Post-RUC Evaluation
		7.38	2009		36			36	78	21	5.0		1.5			1.0	1.0	283	0.0192	ASSH, AAOS,	Pre-RUC Evaluation	
25116	REMOVE WRIST/FOREARM LESION	7.56	2010	1,030	40	10	15	65	60	20	1.0	3.0					0.5	249	0.0307	ASPS	Post-RUC Evaluation	
		7.91	2007		21	25			83	19	4.0		1.5					1.0			Pre-RUC Evaluation	
27792	TREATMENT OF ANKLE FRACTURE	9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0	1.0		1.0	1.0	1.0	281	0.0513	AAOS, AOFAS	Post-RUC Evaluation	
		5.64	2009		47				47	67	21	3.5		1.5				1.0	259	0.0056	Pre-RUC Evaluation	
28120	PART REMOVAL OF ANKLE/HEEL	8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0	1.0		1.0	1.0	1.0	280	0.0263	AAOS, APMA	Post-RUC Evaluation	
		7.56	2009		43				43	51	26	5.0		1.5				1.0	268	0.0304	Pre-RUC Evaluation	
28122	PARTIAL REMOVAL OF FOOT BONE	7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0	1.0		1.0	1.0	1.0	264	0.0249	AAOS, APMA	Post-RUC Evaluation	
		11.97	2009		50				50	89	22	4.0		2.5				1.0	313	0.0631	Pre-RUC Evaluation	
28725	FUSION OF FOOT BONES	12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0		1.0	1.0	1.0	339	0.0496	AOFAS, APMA, AAOS	Post-RUC Evaluation	
		12.21	2009		60				60	120			5.0		1.0			1.0	383	0.0331	Pre-RUC Evaluation	
28730	FUSION OF FOOT BONES	12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0		1.0	1.0	1.0	349	0.0471	AOFAS, APMA, AAOS	Post-RUC Evaluation	
		3.71	2008		17				25	42	36	16	3.5		0.5			1.0	198	-0.0151	Pre-RUC Evaluation	
28825	PARTIAL AMPUTATION OF TOE	6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0						1.0	224	0.0099	ACS, SVS, APMA, AAOS	Post-RUC Evaluation
		9.15	2008		29				25	54	75	28	2.5		1.5			1.0	265	0.0540	Pre-RUC Evaluation	
36821	AV FUSION DIRECT ANY SITE	12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0						1.0	256	0.0823	ACS, SVS, RPA	Post-RUC Evaluation
		10.00	2009		56				56	81	22	2.5		1.0				1.0	257	0.0663	Pre-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAFT	15.13	2010	4,873	40	10	20	70	120	30	1.0	2.0	1.0		1.0	1.0	1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation	
		17.99	2009		55				55	156	37		3.5		1.5			1.0	396.5	0.0671	Pre-RUC Evaluation	
42415	EXCISE PARTOID GLAD/LESION	18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0	1.0		1.0	1.0	1.0	342	0.0843	ACS, AAC-HNS	Post-RUC Evaluation	
		20.87	2009		57				57	182	22		3.5		3.0			1.0	439.5	0.0687	Pre-RUC Evaluation	
42420	EXCISE PARTOID GLAD/LÉSION	21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0	1.0	1.0	1.0	1.0	432	0.0743	ACS, AAC-HNS	Post-RUC Evaluation	
		7.05	2009		47				47	71	19	1.5	0.5					1.0	209	0.0500	Pre-RUC Evaluation	
42440	EXCISE SUBMAXILLARY GLAND	7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0						0.5	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation
		9.97	2009		45				45	67.5	30	1.0	1.0	1.0				1.0	239.5	0.0711	Pre-RUC Evaluation	
49507	PRP I/HERN INIT BLOCK >5 YR	10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0	1.0		1.0	1.0	1.0	260	0.0680	ACS	Post-RUC Evaluation	
		12.36	2009		45				45	90	30	1.0	1.0	1.0				1.0	262	0.0799	Pre-RUC Evaluation	
49521	REREPAIR ING HERNIA, BLOCKED	12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0	1.0		1.0	1.0	1.0	280	0.0795	ACS	Post-RUC Evaluation	
		7.96	2009		45				45	90	30	1.0	1.0	1.0				1.0	232	0.0465	Pre-RUC Evaluation	
49587	RPR UNBIL HERN, BLOCK >5 YR	8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0	1.0		1.0	1.0	1.0	250	0.0459	ACS	Post-RUC Evaluation	
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010		45	15	15	75	90	30	1.0	1.0	1.0		1.0	1.0	1.0	292	0.0806	ACS	New Code in 2009	
49653	LAP VENT/ABD HERN PROC COMP	16.21	2010		45	15	15	75	120	30	2.0	1.0	1.0	1.0	1.0	1.0	1.0	378	0.0726	ACS	New Code in 2009	
49654	LAP INC HERNIA REPAIR	15.03	2010		45	15	15	75	120	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	362	0.0668	ACS	New Code in 2009	
49655	LAP INC HERN REPAIR COMP	18.11	2010		50	15	15	80	150	30	2.0	1.0	1.0	1.0	1.0	1.0	1.0	413	0.0700	ACS	New Code in 2009	
		6.11	2008		47.5				47.5	60	49								156.5	0.0658	Pre-RUC Evaluation	
52341	CYSTO W/URETER STRICTURE TX	5.35	2010	2,105	45	10	15	70	45	20								1.0	135	0.0789	AUA	Post-RUC Evaluation
		6.61	2008		60				60	65	30							1.0	175	0.0590	Pre-RUC Evaluation	
52342	CYSTO W/UP STRICTURE TX	5.85	2010	281	40	10	10	60	60	20								1.0	140	0.0700	AUA	Post-RUC Evaluation
		7.31	2008		60				60	90	30							1.0	200	0.0504	Pre-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	6.55	2010	37	45	10	10	65	60	25								1.0	150	0.0780	AUA	Post-RUC Evaluation
		7.81	2008		60				60	77.5	30							1.0	187.5	0.0650	Pre-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.05	2010	2,447	40	10	10	60	45	20								1.0	125	0.1200	AUA	Post-RUC Evaluation
		8.31	2008		50				50	90	30							1.0	190	0.0640	Pre-RUC Evaluation	
52345	CYSTO/URETERO W/UP STRICTURE	7.55	2010	475	45	10	15	70	45	20								1.0	135	0.1277	AUA	Post-RUC Evaluation
		9.34	2008		45				45	120	49							1.0	214	0.0603	Pre-RUC Evaluation	
52346	CYSTOURERETO W/RENAL STRICT	8.58	2010	144	40	10	10	60	60	20								1.0	140	0.1155	AUA	Post-RUC Evaluation
		10.06	2008		90				90	60	30							1.0	261	0.0727	Pre-RUC Evaluation	
52400	CYSTOURERETO W/CONGEN REPR	8.69	2010	635	72.5	10	15	97.5	40	25	1.0	1.0			1.0	1.0	1.0	1.0	197.5	0.1260	AUA	Post-RUC Evaluation
		9.39	2008		40				40	45	35							1.0	247	0.0613	Pre-RUC Evaluation	
52500	REVISION OF BLADDER NECK	8.14	2010	5,348	45	10	15	70	45	27.5	3.0	1.0						1.0	230.5	0.0582	AUA	Post-RUC Evaluation
		6.89	2008		50				50	38	17	2.0	2.0					1.0	216	0.0509	Pre-RUC Evaluation	
52640	RELIEVE BLADDER CONTRACTURE	4.79	2010	2,217	40	10	10	60	30	20	2.0	2.0						1.0	161	0.0514	AUA	Post-RUC Evaluation

Tables 15 & 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review																						
CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99611	99612	99613	99614	99631	99632	99633	99638	Total Time	IWPUT	Specialty Societies	Review
53445	INSERT URO/VES NCK SPHINCTER	15.21	2009	75				75	126	24		3.0		3.0		1.0	392	0.0546		Pre-RUC Evaluation		
		15.39	2010	1,949	50	15	20	85	90	25	1.0	3.0		1.0	1.0	1.0	418	0.0572	AUA	Post-RUC Evaluation		
54410	REMOVE/REPLACE PENIS PROSTH	16.48	2008	50				50	145	30		2.0	1.0	1.0		1.0	369	0.0635		Pre-RUC Evaluation		
		15.18	2010	1,328	40	10	15	65	120	30	1.0	3.0		1.0			1.0	338	0.0716	AUA	Post-RUC Evaluation	
54530	REMOVAL OF TESTIS	9.31	2008	58				58	58	17		2.5	0.5		1.0	238.5	0.0673		Pre-RUC Evaluation			
		8.46	2010	1,426	57.5	10	15	82.5	60	30	2.0	1.0		0.5	246.5	0.0597	AUA	Post-RUC Evaluation				
57287	REVISE/REMOVE SLING REPAIR	14.49	2008	45				45	70	30	1.0	2.0	2.0		1.0	285	0.0656		Pre-RUC Evaluation			
		11.15	2010	1,795	40	10	10	60	60	20	1.0	3.0		0.5	244	0.0912	AUA, ACOG	Post-RUC Evaluation				
61885	NSRT/REDO NEUROSTIM ARRAY	7.87	2009	50				50	60	25		4.0	1.0	1.0	1.0	1.0	326	-0.027		Pre-RUC Evaluation		
		16.44	2010	4,358	33	3	15	51	45	20		2.0		2.0	0.5	181	0.0567	AANS/CNS	Post-RUC Evaluation			
62263	EPIDURAL LYSIS MULT SESSIONS	6.41	2009	40				40	30	20	2.0		2.0		1.0	200	0.0435		Pre-RUC Evaluation			
		6.54	2010	1,269	33	10	5	48	45	20	1.0	2.0			0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation			
62350	IMPLANT SPINAL CANAL CATH	8.04	2008	70				70	60	125	4.0		1.0	2.0	1.0	487	-0.0715		Pre-RUC Evaluation			
		6.05	2010	6,416	33	10	5	48	60	20		1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
62355	REMOVE SPINAL CANAL CATHETER	6.60	2008	60				60	40	130	3.0		1.0	2.0	1.0	446	-0.1284		Pre-RUC Evaluation			
		4.35	2010	1,461	33	10	5	48	30	20		1.0			0.5	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
62360	INSERT SPINE INFUSION DEVICE	3.68	2008	60				60	55	123	4.0				2.0	1.0	450	-0.1385		Pre-RUC Evaluation		
		4.33	2010	616	33	10	5	48	60	20		1.0			0.5	170	0.0211	AAPMR, ASA, NASS, APM, AANS/CNS	Post-RUC Evaluation			
62361	IMPLANT SPINE INFUSION PUMP	6.59	2008	60				60	60	130	4.0		1.0	2.0	1.0	482	-0.0938		Pre-RUC Evaluation			
		5.65	2010	307	33	10	5	48	60	20		1.0			0.5	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
62362	IMPLANT SPINE INFUSION PUMP	8.58	2008	75				75	90	150	4.0				3.0	1.0	582	-0.0629		Pre-RUC Evaluation		
		6.10	2010	6,570	33	10	5	48	60	20		1.0			0.5	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
62365	REMOVE SPINE INFUSION DEVICE	6.57	2008	60				60	45	125	3.0		1.0	2.0	1.0	446	-0.1123		Pre-RUC Evaluation			
		4.65	2010	1,598	33	10	5	48	45	20		1.0			0.5	155	0.0353	AAPMR, ASA, NASS, APM, AANS/CNS	Post-RUC Evaluation			
63650	IMPLANT NEUROELECTRODES	7.57	2008	56				56	74	19		2.0	2.5		1.0	283	0.0152		Pre-RUC Evaluation			
		7.20	2010	31,144	33	10	5	48	60	20		1.0			0.5	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
63685	INSRT/REDO SPINE N GENERATOR	7.87	2008	53				53	62	18		2.0	2.5		1.0	267	0.0245		Pre-RUC Evaluation			
		6.05	2010	9,343	33	10	5	48	60	20		1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
64708	REVISE ARM/LEG NERVE	6.22	2009	46				46	76	18	2.5		0.5	1.0	228	0.0301		Pre-RUC Evaluation				
		6.36	2010	3,069	35	10	10	55	60	15	3.0	1.0		0.5	220	0.0314	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation				
64831	REPAIR OF DIGIT NERVE	10.23	2008	50				50	74	21		2.5	1.0		1.0	260.5	0.0612		Pre-RUC Evaluation			
		9.16	2010	972	40	10	15	65	60	15	2.0	2.0		0.5	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation				
65285	REPAIR OF EYE WOUND	14.43	2009	52				52	79	32		5.5	0.5		1.0	337.5	0.0730		Pre-RUC Evaluation			
		14.71	2010	1,154	37			15	52	79		5.5	0.5		1.0	337.5	0.0766	AAO	Post-RUC Evaluation			
Codes to be reviewed on the Fourth Five-Year Review Agenda (52640 and 57287) and recent May 2010 Submission (61885)																						
23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values																						
*2010 Post-RUC Review work RVWs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10																						

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11719 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	- 0.44 RVUs	0.38 RVUs ...	- 0.76 RVUs	- 1.39 RVUs	- 0.64 RVUs	- 0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39)$

$$- 0.64 - 0.36 = 8.08$$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs (“starting value”)	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insr/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup>We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs (“starting value”)	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insr/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup>We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC’s most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IWPPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IWPPUT is counterintuitive to the IWPPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011.

Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2008

**Forearm Excision**

CPT code 25116, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicates that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society agreed that there was no compelling evidence to support of a review of the physician work in order to recommend a higher work RVU than is currently assigned to 25116. However, the specialty society noted that current data for 25116 is based on a Harvard survey for intra-service time only and the post-op visits in the database were predicted by CMS using an algorithm rather than a survey. While the specialty society agreed that there was no compelling evidence to increase the value of the service, they also agreed that there was no evidence that the service is misvalued. The specialty society conducted a survey of 55 orthopaedic surgeons to validate physician work, physician time components, and post-operative office visits. The survey resulted in a median pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes, pre-service scrub, dress and wait time of 15 minutes, intra-service time of 60 minutes, and immediate post-service time of 20 minutes. The survey respondents also indicated that the outpatient procedure includes one-half 99238 discharge management service, one 99212 office visit, and three 99213 office visits within its 090 day global period. Further, the survey resulted in a median work RVU of 9.89 and 25<sup>th</sup> percentile work RVU of 9.08. Sixty-nine percent of survey respondents indicated the key reference service 25115, *Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors, (work RVU = 9.89, intra-service time = 90 minutes)*. The key reference service requires greater intra-service time and, therefore, the RUC agreed that it should be valued slightly higher than the surveyed code. Further supporting the current work RVU for 25116, the calculated intra-service work per unit of time (IWPUT) with the surveyed times and post-operative visits is 0.031, which is lower than the key reference service IWPUT of 0.050. The RUC concluded that the incremental difference in

IWP/UT between the survey code and reference code and the difference between the current work RVU of 25116 and 25115 are appropriate to maintain proper rank order between the services.

**The RUC recommends that the work RVU of 7.38 for code 25116 be maintained and recommends that new surveyed times and post-operative visits.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	090	7.38  (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:25116      Tracking Number n/a    Specialty Society Recommended RVU: **7.38**

Global Period: 090

RUC Recommended RVU: **7.38**

CPT Descriptor: Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 50-year-old woman with rheumatoid arthritis and marked extensor tendon synovitis at the wrist and distal forearm requires surgical excision of all diseased synovium.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 20%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 4%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Write preadmission orders for preoperative medications
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform 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.
- Scrub and gown.
- The arm is draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Perform surgical "time out" with operating surgical team

Description of Intra-Service Work: An incision is made on the dorsal aspect of the distal forearm and wrist. Care is taken to protect the dorsal sensory nerves. The dorsal retinaculum is incised along one of its borders and elevated as a flap. The twelve extensor tendons are examined. The hypertrophic and invasive synovium is meticulously removed from each tendon taking care to preserve the tendon. Cultures of any fluid are taken. The excised tenosynovium is sent for culture and to pathology for examination. The dorsal retinaculum is passed beneath (palmar to) the extensor tendons and sutured in place. The tourniquet is then deflated, hemostasis is obtained, a drain is inserted and the wound is closed in layers.

**Description of Post-Service Work:****Post-service work: in facility**

- Application of bulky dressing, reinforced with a splint
- Monitor 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.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

**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)	04/2008				
Presenter(s):	Daniel Nagle, MD; R. Dale Blasier, MD				
Specialty(s):	hand surgery; orthopaedic surgery				
CPT Code:	25116				
Sample Size:	300	Resp N:	55	Response: 18.3 %	
Sample Type:	Random				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate	0.00	2.00	3.00	5.00	12.00
Survey RVW:	7.00	9.08	9.89	10.00	20.00
Pre-Service Evaluation Time:			40.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			15.0		
Intra-Service Time:	30.00	60.00	60.00	80.00	120.00
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.50	99239x 0.00		
Office time/visit(s):	<u>85.0</u>	99211x 0.0	12x 1.0	13x 3.0	14x 0.0
Prolonged Services:	<u>0.0</u>	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	25116				
		<u>Specialty Recommended</u>			
Physician Work RVU:		7.38			
Pre-Service Evaluation Time:		40.0			
Pre-Service Positioning Time:		10.0			
Pre-Service Scrub, Dress, Wait Time:		15.0			
Intra-Service Time:		60.00			
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.5	99239x 0.0		
Office time/visit(s):	<u>85.0</u>	99211x 0.0	12x 1.0	13x 3.0	14x 0.0
Prolonged Services:	<u>0.0</u>	55x 0.0	56x 0.0	57x 0.0	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
25115	090	9.89	RUC Time

CPT Descriptor Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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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: 69.0 %

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 25116	<u>Key Reference CPT Code:</u> 25115	<u>Source of Time</u> RUC Time
Median Pre-Service Time	65.00	45.00	
Median Intra-Service Time	60.00	90.00	
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	19.0	0.00	
Median Office Visit Time	85.0	92.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	249.00	257.00	

Other time if appropriate		
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### 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	3.53
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.47	3.45
--	------	------

Urgency of medical decision making	2.97	2.95
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#### Technical Skill/Physical Effort (Mean)

Technical skill required	3.68	3.71
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Physical effort required	3.11	3.11
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#### Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.37	3.37
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Outcome depends on the skill and judgment of physician	3.71	3.71
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Estimated risk of malpractice suit with poor outcome	3.13	3.11
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### INTENSITY/COMPLEXITY MEASURES

### CPT Code

### Reference Service 1

#### Time Segments (Mean)

Pre-Service intensity/complexity	3.43	3.44
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Intra-Service intensity/complexity	3.51	3.47
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Post-Service intensity/complexity	3.08	3.06
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#### **Additional Rationale**

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

Our consensus panel does not believe there is compelling evidence of change in patient or technology to recommend an increase for code 25116. The current RVW (7.38) and Harvard data resulted in a low IPUT = 0.020. The current RVW (7.38) and current survey data also result in a low IPUT = 0.031. Our expert panel believes this intensity (which is less than the intensity of 99213), is inconsistent with the intra-operative work of a procedure performed under

anesthesia that has a risk of immediate tendon, artery and/or nerve injury. However, this alone is not compelling evidence. We also note that if a surgeon spent the total time for 25116 (249 min) performing 99213 E/M services (23 minutes), then the total RVWs would be 35% or 2.58 RVUs greater. [(249 min for 25116) / (23 min for 99213) x (0.92 RVUs for 99213) = 9.96 RVUs]. However, this is also not compelling evidence.

Without compelling evidence, we understand the current review is limited to evaluating whether the current RVW is overvalued. We agree with the survey visit data that indicate the typical patient is discharged from a facility on the day of the procedure (ie, same-day discharge). In comparison to the key reference code 25115, the survey code 25116 requires less intra-operative time. Pre- and post-service work would be similar for both codes. The value for 25116 (RVW=7.38) is correctly less than the value for 25115 (RVW=9.89).

Given the low IPUT (0.031) for 25116 and comparison to the reference code total work, there is no compelling evidence to indicate 25116 is overvalued at 7.38 RVWs. We recommend the median survey time and visit data.

#### **Additional Supporting References:**

CPT	descriptor	08RVW	TOTAL TIME	INTRA TIME
25109	Excision of tendon, forearm and/or wrist, flexor or extensor, each	6.81	191	40
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	6.85	211	60
25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum	7.38	249	60
67911	Correction of lid retraction	7.38	183	50
43272	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	7.38	105	60
37765	Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions	7.63	201	60
33207	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular	8.00	239	60
25607	Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation	9.35	275	60

#### **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

CPT Code: 25116

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 25116

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery      How often? Sometimes

Specialty plastic surgery      How often? Sometimes

Specialty hand surgery                              How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

**Specialty**                    **Frequency**                    **Percentage**            **%**

Specialty                      Frequency                      Percentage                      %

Specialty                      Frequency                      Percentage 0.00 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 1,107  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2006 data

Specialty orthopaedic surgery Frequency 700 Percentage 63.23 %

Specialty plastic surgery Frequency 300 Percentage 27.10 %

Specialty hand surgery Frequency 150 Percentage 13.55 %

Do many physicians perform this service across the United States? No

## **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 25116 (use current code)

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
February 2008 – Initial Review

**Submandibular Gland Excision**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT code 42440 *Excision of submandibular (submaxillary) gland*, the RUC asked the specialties to provide additional rationale regarding the appropriateness of the current work RVU of 7.13. The specialties' enclosed letter and table of comparison codes emphasize the need to use relativity in reviewing physician work. The specialties also explained that the Harvard study measured post-operative time and did not articulate visits. The visits were extrapolated later for practice expense purposes. The RUC notes that the specialty survey actually supported a higher work RVU (median = 12.00), however compelling evidence was not presented in February 2008. The survey times for 42440 are 55 minutes of pre-time, 60 minutes intra-time, 20 minutes post-time,  $\frac{1}{2}$  day discharge day management and 2 office visits. CPT code 42440 is similar in work to 38520 *Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad* (work RVU = 7.03, pre-time = 45 minutes; intra-time = 60 minutes, post-time=30 minutes,  $\frac{1}{2}$  day discharge day and 2 office visits) and 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* (work RVU = 7.20, pre-time = 48 minutes; intra-time = 60 minutes; post-time = 20 minutes,  $\frac{1}{2}$  day discharge and 1 office visit).

**The RUC reaffirms its recommendation of 7.13 for CPT Code 42440.**

**February 2008 RUC Recommendations**

CPT code 42440, *Excision of submandibular (submaxillary) gland*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. Based on a survey of 25 surgeons, the presenters recommended the following median survey times, pre-service evaluation = 30, pre-service positioning = 10, pre-service scrub, dress, and wait = 15, intra-service = 60, immediate post-service = 20. The specialty society presenter and the RUC agreed that the median survey physician time was appropriate. The specialty society recommended two post-service office visits, one 99212, one 99213, and one-half 99238 discharge day management visits. The specialty society presenter clarified the increase in intensity of office visits, noting that rather than an overnight stay in the hospital, the typical patient is discharged the same day with tubes in their neck and a more intense office visits is needed to remove the tube and check the other dressings. There is also a slightly less intense service for general follow-up care with the patient regarding this service. The specialty society did not agree with the survey median of 12.00 or the 25<sup>th</sup> percentile of 10.00, but rather recommended maintaining the current RVU of 7.05 (7.13 in 2010).

Further, this recommendation was further supported when the RUC considered another reference service, 38520, *Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad*, (work RVU = 6.95, intra-service time = 60 minutes), which was reviewed by the RUC in the second Five-Year Review. This service contains the same number and level of office visits as the surveyed code. The RUC also compared the intra-service work intensity between the two codes and noted that the IPUT of the survey code was 0.0596 and for 38520, the IPUT was nearly identical at 0.0560. The RUC agreed and noted that while the hospital visits were removed, the intensity of the office visits increased significantly and the pre- and post-service times increased slightly. In consideration of the similarity to the reference service, 38520, and the RUC agreed that 7.05 (7.13 in 2010) is an appropriate valuation.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
42440	Excision of submandibular (submaxillary) gland	090	7.13 (No Change)

August 14, 2010

Barbara Levy, MD  
Chair, AMA/Relative Value Update Committee  
American Medical Association  
515 N. State St.  
Chicago, IL 60610

RE: 42440 Excision of submandibular (submaxillary) gland

Dear Dr. Levy,

In the Proposed Rule for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC "re-review" the RUC recommendations for existing CPT codes, originally identified as site-of-service anomalies. The RUC requested that each specialty society prepare a letter and supporting documents explaining why the listed codes are appropriately valued and explain why the methodology described by CMS would not result in a substantially different work RVU from the previously submitted RUC recommendation.

In February 2008, the American Academy of Otolaryngology – Head and Neck Surgery and American College of Surgeons indicated to the RUC that incorrect assumptions were made in the initial valuation for 42440. Specifically, a flawed mechanism or methodology was used in the previous valuation because not all providers of the service were included in the review.

Additionally, we noted that the Harvard study of 42440 only included estimates for time as shown in the table below. Time was multiplied by assigned intensities to calculate total work, which was then transformed to work relative value units (ie, the building block methodology, as use by Harvard).

CPT	EVAL	POSIT	SDW	INTRA	IMM-SD	HOSP	OFF
42440	22	0	25	71	19	18	25

We emphasize that Harvard study estimates were for time. Number and level of hospital and/or office visits were imputed by a CMS contractor for purposes of reviewing practice expense RVUs many years after completion of the Harvard study. Additionally, we also note that for many of the codes, pre- and post-time was predicted using an algorithm that took into account the surveyed intra-service time and the pre- and post-times of an anchor code.

Of importance for 42440 is the fact that the estimated 18 minutes of hospital time was transformed to  $0.5 \times 99231$  plus  $1.0 \times 99238$  and the estimated 25 minutes of office time was transformed to  $1.5 \times 99212$ . Given this information, it should be clear that work RVUs for visits in current survey data should not be added and/or subtracted from the work RVU for 42440 because time, not visits, was used as building blocks to calculate the initial work RVU.

Barbara Levy, MD  
August 14, 2010  
Page 2

**We strongly disagree with the Agency's perception that subtracting E/M work RVUs from a value that was developed using minutes is "reverse building block."**

The concept of reverse building block can only be used in two ways: 1) If a work RVU was calculated using BBM of time and visits (eg, STS valuation of codes in 2005, occasion code reviewed by the RUC in facilitation), then changes to time and/or visits years later can be used to re-calculate the work RVU; or 2) if a work RVU was calculated using BBM of time and assigned intensities (eg, Harvard valuation of codes), then changes to time can be used to recalculate the work RVU, if you also use the Harvard assigned intensities.

The methodology that CMS describes as "reverse building block" is incorrect. In reviewing codes that are still Harvard-based, the Agency should be looking at the original Harvard study times and Harvard assigned intensities – not 2010 work RVUs for E/M codes. It is no wonder that the Agency's calculations for some codes result in negative work, since the Agency was mixing data elements incorrectly. Additionally, if a code under review was not Harvard-based, but instead was a RUC recommendation (eg, a new or revised code), the Agency should also be reviewing whether the RUC recommendation was based on building blocks or whether it was tied to one or more other codes using "magnitude estimation." Just because a code includes visits, does not mean the procedure's work RVU was calculated using a building block methodology to include the full value of the work RVUs of E/M codes.

It is a well established that some low volume codes reviewed during the Harvard study had time predicted by algorithm and/or estimated by a low number of physicians and/or physicians of the wrong specialty. When reviewing these codes, the RUC has primarily relied on magnitude estimation to determine the appropriate relative value for a code. This is similar to the Technical Expert Groups and Refinement Panels that CMS has utilized since the inception of the fee schedule. Further, when using magnitude estimation and refinement, both the RUC and CMS look for other codes for comparison to support a recommendation.

In addition to reviewing the survey data and key reference code for 42440, the RUC compared 42440 Excision of submandibular (submaxillary) gland to code 38520 Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad which has the same intra-operative time and the same number and level of office visits as the surveyed code. The RUC also discussed an apparent shift in post-work data from the visits imputed for practice expense purposes to current survey data and concluded that total work had not changed. We believe this magnitude estimation judgment would have also stood up to a review by an Agency refinement panel, which typically uses magnitude estimation and comparison to other codes for refinement.

Barbara Levy, MD

August 14, 2010

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**We strongly disagree with the Agency's recommendation for a new value for 42440 that subtracts and adds work RVUs based on imputed visits to match current survey data. This process disregards the peer review process and magnitude estimation that has been used for 20 years to maintain a relative value scale for the codes in the Physician Fee Schedule.**

In addition to reference code 38520 identified by the RUC as a good comparison to support maintaining the work RVU for 42440, we have attached a table of codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IPUT. We believe a review – by magnitude estimation – of this list of procedures adds further support that the current work RVU for 42440 is a correct "relative" value.

Sincerely,

Wayne Koch, MD, FACS

Advisor, American Academy of Otolaryngology – Head and Neck Surgery

Christopher Senkowski, MD, FACS

Advisor, American College of Surgeons

## RUC-Reviewed Comparison Codes to Support the Current Work RVU for Code 42440

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IINPUT	Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2006	49324	Laparoscopy, surgical; with insertion of intraperitoneal cannula or catheter, permanent	010	6.32	0.058	162	20	10	10	60	20	0.5	1	
2000	38525	Biopsy or excision of lymph node(s); open, deep axillary node(s)	090	6.43	0.059	178	45			45	30	0.5	1	1
2000 MPC	49585	Repair umbilical hernia, age 5 years or older; reducible	090	6.59	0.063	178	45			45	30	0.5	1	1
2000	38305	Drainage of lymph node abscess or lymphadenitis; extensive	090	6.68	0.065	186	45			30	30	0.5	2	1
2000	38308	Lymphangiotomy or other operations on lymphatic channels	090	6.81	0.068	178	45			45	30	0.5	1	1
2006	49325	Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed	010	6.82	0.067	162	20	10	10	60	20	0.5	1	
2001 MPC	57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	090	6.87	0.059	181	48			55	20	0.5	1	1
2000	38520	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	090	7.03	0.054	193	45			60	30	0.5	1	1
2008	42440	Excision of submandibular (submaxillary) gland	090	7.13	0.060	193	30	10	15	60	20	0.5	1	1
2008	63650	Percutaneous implantation of neurostimulator electrode array, epidural	010	7.20	0.069	170	33	10	5	60	20	0.5	1	
2003	37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	090	7.71	0.066	201	33	10	15	60	25	0.5	1	1
2008	38542	Dissection, deep jugular node(s)	090	7.95	0.066	198	33	10	15	60	15	0.5	2	
2005 MPC	49505	Repair initial inguinal hernia, age 5 years or older; reducible	090	7.96	0.065	198	20	15	15	70	20	0.5	1	1
2008	25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	090	8.08	0.056	235	40	10	15	60	20	0.5	1	3
2000	38530	Biopsy or excision of lymph node(s); open, internal mammary node(s)	090	8.34	0.063	206	45			73	30	0.5	1	1
2008	54530	Orchiectomy, radical, for tumor; inguinal approach	090	8.46	0.060	247	58	10	15	60	30	0.5	1	2

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Last Year Before RUC Review	Work RVU	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75				75	120	43	2	2	2		1	1	1	428	0.0145		Pre-RUC Evaluation	
		10.03	2010	1,123	60	10	15	85	90	30	2	2						283	0.0530	AAOMS	Post-RUC Evaluation	
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49				49	62	23		3.5		0.5			1	238	0.0866		Pre-RUC Evaluation	
		9.23	2010	1,237	40	15	15	70	60	20	2.0	2.0		0.5			0.5	247	0.0648	AAOS	Post-RUC Evaluation	
25116	REMOVE WRIST/FOREARM LESION	7.38	2009	36				36	78	21		5.0		1.5			1.0	283	0.0192		Pre-RUC Evaluation	
		7.56	2010	1,030	40	10	15	65	60	20	1.0	3.0				0.5	249	0.0307	ASSH, AAOS, ASPS	Post-RUC Evaluation		
27792	TREATMENT OF ANKLE FRACTURE	7.91	2007	21				83	19	4.0		1.5		1.0			1.0	281	0.0513	AAOS, AOFAS	Post-RUC Evaluation	
		9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0	1.0				1.0	259	0.0056		Pre-RUC Evaluation	
28120	PART REMOVAL OF ANKLE/HEEL	5.64	2009	47				47	67	21		3.5		1.5			1.0	280	0.0263	AAOS, APMA	Post-RUC Evaluation	
		8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0	1.0				1.0	268	0.0304		Pre-RUC Evaluation	
28122	PARTIAL REMOVAL OF FOOT BONE	7.56	2009	43				43	51	26		5.0		1.5			1.0	264	0.0249	AAOS, APMA	Post-RUC Evaluation	
		7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0	1.0				1.0	313	0.0631		Pre-RUC Evaluation	
		11.97	2009		50			50	89	22		4.0		2.5			1.0	339	0.0496	AOFAS, APMA, AAOS	Post-RUC Evaluation	
28725	FUSION OF FOOT BONES	12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0				1.0	383	0.0331		Pre-RUC Evaluation	
		12.21	2009		60			60	120			5.0		1.0			1.0	383	0.0331		Pre-RUC Evaluation	
28730	FUSION OF FOOT BONES	12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0				1.0	349	0.0471	AAOS	Post-RUC Evaluation	
		3.71	2008		17			25	42	36	1.6	3.5		0.5			1.0	198	0.0151		Pre-RUC Evaluation	
28825	PARTIAL AMPUTATION OF TOE	6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0					1.0	224	0.0099	AAOS	Post-RUC Evaluation	
		9.15	2008		29			25	54	75	28	2.5		1.5			1.0	265	0.0540		Pre-RUC Evaluation	
36821	AV FUSION DIRECT ANY SITE	12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0					1.0	256	0.0823	ACS, SVS, RPA	Post-RUC Evaluation	
		10.00	2009		56			56	81	22	2.5	2.5	1.0				1.0	257	0.0663		Pre-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAPH	15.13	2010	4,873	40	10	20	70	120	30	1.0	2.0					1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation	
		17.99	2009		55			55	156	37		3.5		1.5			1.0	396.5	0.0671		Pre-RUC Evaluation	
42415	EXCISE PARTOID GLAD/LESION	18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0					1.0	342	0.0843	ACS, AAO-HNS	Post-RUC Evaluation	
		20.87	2009		57			57	182	22		3.5		3.0			1.0	439.5	0.0687		Pre-RUC Evaluation	
42420	EXCISE PARTOID GLAD/LESION	21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0	1.0			1.0	432	0.0743	ACS, AAO-HNS	Post-RUC Evaluation	
42440	EXCISE SUBMAXILLARY GLAND	7.05	2009		47			47	71	19	1.5	0.5					1.0	209	0.0500		Pre-RUC Evaluation	
		7.13	2010		2,088	30	10	15	55	60	20	1.0	1.0				0.5	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation	
49507	PRP/I/HERN INIT BLOCK >5 YR	9.97	2009		45			45	67.5	30	1.0	1.0					1.0	239.5	0.0711		Pre-RUC Evaluation	
		10.05	2010		11,879	40	3	20	63	70	30	1.0	1.0				1.0	260	0.0680	ACS	Post-RUC Evaluation	
49521	REREPARING HERNIA; BLOCKED	12.36	2009		45			45	90	30	1.0	1.0					1.0	262	0.0799		Pre-RUC Evaluation	
		12.44	2010		2,815	40	3	20	63	90	30	1.0	1.0				1.0	280	0.0795	ACS	Post-RUC Evaluation	
49587	RPR UNBIL HERN, BLOCK >5 YR	7.96	2009		45			45	60	30	1.0	1.0					1.0	232	0.0465		Pre-RUC Evaluation	
		8.04	2010		9,212	40	3	20	63	60	30	1.0	1.0				1.0	250	0.0459	ACS	Post-RUC Evaluation	
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010		45			45	90	30	1.0	1.0						292	0.0806	ACS	New Code in 2009	
49653	LAP VENT/ABD HERN PROC COMP	16.21	2010		45			45	120	30	2.0	1.0	1.0	1.0				1.0	378	0.0726	ACS	New Code in 2009
49654	LAP INC HERNIA REPAIR	15.03	2010		45			45	15	15	75	120	30	1.0	1.0		1.0	362	0.0668	ACS	New Code in 2009	
49655	LAP INC HERN REPAIR COMP	18.11	2010		50			50	15	15	80	150	30	2.0	1.0	1.0	1.0	413	0.0700	ACS	New Code in 2009	
52341	CYSTO W/URETER STRICTURE TX	6.11	2008		47.5			47.5	60	49								156.5	0.0658		Pre-RUC Evaluation	
		5.35	2010		2,105	45	10	15	70	45	20							135	0.0789	AUA	Post-RUC Evaluation	
52342	CYSTO W/UP STRICTURE TX	6.61	2008		60			60	65	30								175	0.0590		Pre-RUC Evaluation	
		5.85	2010		281	40	10	10	60	60	20							140	0.0700	AUA	Post-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	7.31	2008		60			60	90	30								200	0.0504		Pre-RUC Evaluation	
		6.55	2010		37	45	10	10	65	60	25							150	0.0780	AUA	Post-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.81	2008		60			60	77.5	30								187.5	0.0650		Pre-RUC Evaluation	
		7.05	2010		2,447	40	10	10	60	45	20							125	0.1200	AUA	Post-RUC Evaluation	
52345	CYSTO/URETERO W/UP STRICTURE	8.31	2008		50			50	90	30								190	0.0640		Pre-RUC Evaluation	
		7.55	2010		475	45	10	15	70	45	20							135	0.1277	AUA	Post-RUC Evaluation	
52346	CYSTOURERETO W/RENAL STRICT	9.34	2008		45			45	120	49								214	0.0603		Pre-RUC Evaluation	
		8.58	2010		144	40	10	10	60	60	20							140	0.1155	AUA	Post-RUC Evaluation	
52400	CYSTOURERETO W/CONGEN REPR	10.06	2008		90			90	60	30	1.0	1.0						1.0	261	0.0727		Pre-RUC Evaluation
		8.69	2010		635	72.5	10	15	97.5	40	25	1.0	1.0				0.5	197.5	0.1260	AUA	Post-RUC Evaluation	
52500	REVISION OF BLADDER NECK	9.39	2008		40			40	45	35								1.0	247	0.0613		Pre-RUC Evaluation
		8.14	2010		5,348	45	10	15	70	45	27.5	3.0	1.0				0.5	230.5	0.0582	AUA	Post-RUC Evaluation	
52640	RELIEVE BLADDER CONTRA	6.89	2008		50			50	39	17	2.0	2.0						110	0.216	0.0509		Pre-RUC Evaluation
		4.79	2010		2,217	40	10	10	60	30	20	2.0					0.5	161	0.0514	AUA	Post-RUC Evaluation	

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		2009	2009	1,949	75	15	20	85	75	126	24	3.0	3.0	10	10	1.0	1.0	1.0	1.0	392	0.0546	Pre-RUC Evaluation
53445	INSERT URO/VES NCK SPHINCTER	15.39	2010	1,949	50	15	20	85	90	25	10	3.0	10	1.0	1.0	1.0	1.0	1.0	418	0.0572	AUA	Post-RUC Evaluation
54410	REMOVE/REPLACE PENIS PROSTH	15.18	2010	1,328	40	10	15	65	120	30	10	3.0	10	1.0	1.0	1.0	1.0	1.0	338	0.0716	AUA	Post-RUC Evaluation
54530	REMOVAL OF TESTIS	9.31	2008		58			58	58	17		2.5	0.5		1.0	1.0	1.0	1.0	238.5	0.0673	Pre-RUC Evaluation	
		8.46	2010	1,426	57.5	10	15	82.5	60	30	2.0	1.0			0.5	246.5	0.0597	AUA	Post-RUC Evaluation			
57267	REVISE/REMOVE SLING REPAIR	11.49	2008		46			45	70	30	10	2.0	2.0	10	10	1.0	1.0	1.0	285	0.0656	Pre-RUC Evaluation	
		11.15	2010	1,795	40	10	10	60	60	20	10	3.0	10	1.0	1.0	1.0	1.0	1.0	244	0.0912	AUA, ACOG	Post-RUC Evaluation
61685	INSRT/REDO NEUROSTIM ARRAY	7.67	2009		50			50.5	60	25		4.0	1.0	1.0	1.0	1.0	1.0	1.0	325	0.027	Pre-RUC Evaluation	
		6.44	2010	4,358	53.5	3	15	51	45	20	20	2.0	2.0	0.5	1.0	1.0	1.0	1.0	191	0.0567	AANS/CNS	Post-RUC Evaluation
		6.41	2009		40			40	30	20	2.0	2.0	2.0	1.0	200	0.0435		Pre-RUC Evaluation				
62263	EPIDURAL LYSIS MULT SESSIONS	6.54	2010	1,269	33	10	5	48	45	20	1.0	2.0			0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation			
		8.04	2008		70			70	60	125	4.0		1.0	2.0	1.0	487	-0.0715		Pre-RUC Evaluation			
62350	IMPLANT SPINAL CANAL CATH	6.05	2010	6,416	33	10	5	48	60	20		1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
		6.60	2008		60			60	40	130	3.0		1.0	2.0	1.0	446	-0.1284		Pre-RUC Evaluation			
62355	REMOVE SPINAL CANAL CATHETER	4.35	2010	1,461	33	10	5	48	30	20		1.0			0.5	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
		3.68	2008		60			60	55	123	4.0			2.0	1.0	450	-0.1385		Pre-RUC Evaluation			
62360	INSERT SPINE INFUSION DEVICE	4.33	2010	616	33	10	5	48	60	20	1.0			0.5	170	0.0211	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation				
		6.59	2008		60			60	60	130	4.0		1.0	2.0	1.0	482	-0.0938		Pre-RUC Evaluation			
62361	IMPLANT SPINE INFUSION PUMP	5.65	2010	307	33	10	5	48	60	20	1.0			0.5	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation				
		8.58	2008		75			75	90	150	4.0			3.0	1.0	582	-0.0629		Pre-RUC Evaluation			
62362	IMPLANT SPINE INFUSION PUMP	6.10	2010	6,570	33	10	5	48	60	20		1.0			0.5	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
		6.57	2008		60			60	45	125	3.0		1.0	2.0	1.0	446	-0.1123		Pre-RUC Evaluation			
62365	REMOVE SPONE INFUSION DEVICE	4.65	2010	1,598	33	10	5	48	45	20		1.0			0.5	155	0.0353	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation			
		7.57	2008		56			56	74	19		2.0		2.5	1.0	283	0.0152		Pre-RUC Evaluation			
63650	IMPLANT NEUROELECTRODES	7.20	2010	31,144	33	10	5	48	60	20		1.0			0.5	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
		7.87	2008		53			53	62	18	2.0		2.5	1.0	267	0.0245		Pre-RUC Evaluation				
63685	INSRT/REDO SPINE N GENERATOR	6.05	2010	9,343	33	10	5	48	60	20		1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
		6.22	2009		46			46	76	18	2.5		0.5	1.0	228	0.0301		Pre-RUC Evaluation				
64708	REVISE ARM/LEG NERVE	6.36	2010	3,069	35	10	10	55	60	15	3.0	1.0		0.5	220	0.0314	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation				
		10.23	2008		50			50	74	21		2.5	1.0	1.0	260.5	0.0612		Pre-RUC Evaluation				
64831	REPAIR OF DIGIT NERVE	9.16	2010	972	40	10	15	65	60	15	2.0	2.0		0.5	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation				
65285	REPAIR OF EYE WOUND	14.43	2009	1,154	52			52	79	32	5.5	0.5	1.0	337.5	0.0730		Pre-RUC Evaluation					
		14.71	2010		37			15	52	79	32	5.5	0.5	1.0	337.5	0.0766	AAO	Post-RUC Evaluation				

Codes to be reviewed on the Fourth Five-Year Review Agenda (52640 and 57287) and recent May 2010 Submission (61885).

23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values.

\*2010 Post-RUC Review work RVVs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11179 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	- 0.44 RVUs	0.38 RVUs ...	- 0.76 RVUs	- 1.39 RVUs	- 0.64 RVUs	- 0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39) = 8.08$

$- 0.64 - 0.36 = 8.08$   
 The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congenl repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insrt/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insrt/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IPUT is counterintuitive to the IPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2008

**Submandibular Gland Excision**

CPT code 42440, *Excision of submandibular (submaxillary) gland*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. Based on a survey of twenty-five surgeons, the presenters recommended the following median survey times, pre-service evaluation = 30, pre-service positioning = 10, pre-service scrub, dress, and wait = 15, intra-service = 60, immediate post-service = 20. The specialty society presenter and the RUC agreed that the median survey physician time was appropriate. The specialty society recommended two post-service office visits, one 99212, one 99213, and one-half 99238 discharge day management visits. The specialty society presenter clarified the increase in intensity of office visits, noting that rather than an overnight stay in the hospital, the typical patient is discharged the same day with tubes in their neck and a more intense office visits is needed to remove the tube and check the other dressings. There is also a slightly less intense service for general follow-up care with the patient regarding this service. The specialty society did not agree with the survey median of 12.00 or the 25<sup>th</sup> percentile of 10.00, but rather recommended maintaining the current RVU of 7.05.

Further, this recommendation was further supported when the RUC considered another reference service, 38520, *Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad*, (work RVU = 6.95, intra-service time = 60 minutes), which was reviewed by the RUC in the second Five-Year Review. This service contains the same number and level of office visits as the surveyed code. The RUC also compared the intra-service work intensity between the two codes and noted that the IWP/UT of the survey code was 0.0596 and for 38520, the IWP/UT was nearly identical at 0.0560. The RUC agreed and noted that while the hospital visits were removed, the intensity of the office visits increased significantly and the pre- and post-service times increased slightly. In consideration of the similarity to the reference service, 38520, and the RUC agreed that 7.05 is an appropriate valuation. **The RUC recommends a work RVU of 7.05.**

### **Practice Expense**

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
42440	Excision of submandibular (submaxillary) gland	090	7.05

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:42440      Tracking Number  
 Global Period: 090

Specialty Society Recommended RVU: 7.05  
 RUC Recommended RVU: 7.05

CPT Descriptor: Excision of submandibular (submaxillary) gland

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 25-year-old man presents with a history of recurrent right submandibular sialadenitis. The patient undergoes an excision of the right submandibular gland.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 4%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Assure appropriate selection, timing, and administration of DVT prophylaxis.
- Assess need for beta-blockers, order as required.
- Review medical history, pathology, and radiology report
- Review radiographic images
- Review results of preoperative testing (labs, EKG, CXR)
- Review reports of consultants providing preoperative assessment and clearance as indicated
- Meet with patient and family to review planned procedure and postoperative management
- Reexamine patient to ensure that physical findings have not changed and dictate history and physical
- Obtain informed consent
- Review hospital consent, mark patient
- Review airway and medical management with anesthesiologist
- Review planned procedure with OR staff
- Verify that all required instruments and supplies are available
- Change into scrub clothes
- Monitor/assist with positioning of the patient
- Ensure that radiographic images are available in the OR
- Mark planned incision
- Inject planned incision with vasoconstrictor
- Monitor/assist with prepping and draping
- Scrub and gown
- Perform surgical "time out" with operating surgical team.

Description of Intra-Service Work:

Under anesthesia, an incision is made in lower part of submandibular triangle. Skin flaps are elevated in the subplatysmal plane inferiorly to the level of the digastric muscle, and superiorly along the capsule of the submandibular gland to the lower edge of the mandible, identifying and preserving the marginal mandibular branch of the facial nerve. The gland is dissected from surrounding tissue inferiorly, and the facial artery and veins are divided and ligated. The dissection is

continued to mobilize the posterior aspect of the gland, identifying and preserving the hypoglossal nerve. The mylohyoid muscle is retracted anteriorly to expose and dissect the deep aspect of the gland, identifying and preserving the lingual nerve, and ligating and dividing the neurovascular bundle between the lingual nerve and the gland. Wharton's duct is divided and ligated and the gland is removed and sent to pathology. The wound is irrigated and hemostasis obtain. All structures are inspected including the hypoglossal, lingual and marginal mandibular nerves. A deep drain is placed and the wound closed in layers.

#### Description of Post-Service Work:

##### Post-operative Work – Facility:

- Apply sterile dressings. Monitor patient during reversal of anesthesia. Monitor transport of patient from OR to recovery room. Discuss postoperative recovery care with anesthesia and nursing staff. Write postoperative orders. Discuss procedure and outcome with family in waiting area. Examine the patient to ensure proper drain function and assess applicable nerve function. Write postoperative note. Dictate operative note and copy to referring physician.
- Check wound and monitor patient progress. Chart notes.
- Monitor overall medical condition of the patient including fluid balance, vital signs, and urinary function
- Assess pain scores and adequacy of analgesia.
- Discuss post-discharge management with nursing staff and answer questions
- Home restrictions (i.e., diet, activity, bathing) are discussed with the patient, family members and discharging nurse.
- Write prescriptions for medications and supplies needed post-discharge
- Perform medication reconciliation
- All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

##### Post-operative Work – Office:

- Examine and talk with patient. Ensure that neck range of motion, phonation, respiration, and swallowing have returned to their pre-morbid state.
- Monitor nerve functional deficits, if any
- Remove sutures
- Monitor output and remove drain if present
- Answer patient and family questions
- Review pathology report
- Discuss pathology report with patient and need for any additional testing or consultation
- Assess for adequacy of pain control
- Discuss advancing daily activities with patient
- Discuss long term scar management with patient
- Arrange for any indicated additional testing and review results
- Arrange for any indicated consultation, prepare documents for transmission to appropriate consultants, review reports from consultants.
- Discuss progress with referring physician(s) (verbal and written).
- Dictate progress notes for medical chart

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>		01/2008				
<b>Presenter(s):</b>	Jane T. Dillon, MD, FACS Charles Mabry, MD, FACS Christopher Senkowski, MD, FACS					
<b>Specialty(s):</b>	American Academy of Otolaryngology - Head and Neck Surgery American College of Surgeons					
<b>CPT Code:</b>	42440					
<b>Sample Size:</b>	92	<b>Resp N:</b>	25	<b>Response:</b> 27.1 %		
<b>Sample Type:</b>	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>		2.00	3.00	<b>5.00</b>	6.00	20.00
<b>Survey RVW:</b>		6.00	10.00	<b>12.00</b>	15.00	25.00
<b>Pre-Service Evaluation Time:</b>				<b>30.0</b>		
<b>Pre-Service Positioning Time:</b>				<b>10.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>15.0</b>		
<b>Intra-Service Time:</b>		30.00	55.00	<b>60.00</b>	90.00	120.00
<b>Immediate Post Service-Time:</b>	<b><u>20.00</u></b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.50	99239x 0.00			
Office time/visit(s):	<u>39.0</u>	99211x 0.0	12x 1.0	13x 1.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

<b>CPT Code:</b> 42440		
		<b>Specialty Recommended</b>
<b>Physician Work RVU:</b>		<b>7.05</b>
<b>Pre-Service Evaluation Time:</b>		<b>30.0</b>
<b>Pre-Service Positioning Time:</b>		<b>10.0</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>15.0</b>
<b>Intra-Service Time:</b>		<b>60.00</b>
<b>Immediate Post Service-Time:</b>	<b><u>20.00</u></b>	
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0 99292x 0.0
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0 99232x 0.0 99233x 0.0
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.5 99239x 0.0
Office time/visit(s):	<u>39.0</u>	99211x 0.0 12x 1.0 13x 1.0 14x 0.0 15x 0.0

Prolonged Services:	<b>0.0</b>	99354x <b>0.0</b> 55x <b>0.0</b> 56x <b>0.0</b> 57x <b>0.0</b>
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**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
38700	090	12.68	RUC Time

CPT Descriptor Suprahyoid lymphadenectomy

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 68.0 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 42440	<u>Key Reference CPT Code:</u> 38700	<u>Source of Time</u> RUC Time
Median Pre-Service Time	55.00	60.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	58.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	39.0	62.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	193.00	300.00
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	2.76	3.41
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.82	3.29
--	------	------

Urgency of medical decision making	2.59	3.06
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.47	3.41
--------------------------	------	------

Physical effort required	2.71	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.29	3.24
---	------	------

Outcome depends on the skill and judgment of physician	3.53	3.41
--	------	------

Estimated risk of malpractice suit with poor outcome	3.24	3.18
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.94	3.19
----------------------------------	------	------

Intra-Service intensity/complexity	3.18	3.31
------------------------------------	------	------

Post-Service intensity/complexity	2.59	2.94
-----------------------------------	------	------

**Additional Rationale**

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

Current data for 42440 is based on a Harvard survey of otolaryngologists. General surgeons were not surveyed. The current Harvard based RVW (7.05) and Harvard data result in a low IPUT = 0.051.

Our expert consensus panel carefully reviewed the survey data for 42440 and believe that incorrect assumptions were made in the previous valuation for the service, such as:

1. Flawed mechanism or methodology used in the previous valuation because only 11 general surgeons were surveyed for intra-operative time, although otolaryngologists are significant providers of this service.

Our expert consensus panel agrees with the median survey facility visit data that indicates the typical patient is discharged from a facility on the day of the procedure. This however does not mean that the post-operative office visits will remain unchanged compared with twenty years ago. The physician work that would have been provided in the facility must now be provided in the office thus explaining the need for higher level office work.

In comparison to the key reference code 38700 (Suprahyoid lymphadenectomy), the survey code 38542 is less total work, especially with respect to intra-operative time. The survey median RVW and 25<sup>th</sup> percentile RVW result in an IPUT that is inconsistent with the intra-operative work compared with other similar services. **We recommend current RVW of 7.05 (IPUT = 0.060) and median survey time and visit data.** We also offer two MPC codes 30520 and 49505 with slightly lower and slightly higher RVWs.

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) same code; no change

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

**Specialty Otolaryngology**      How often? Commonly

Specialty Gen Surgery                              How often? Sometimes

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 0

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency unavailable

Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %
Specialty	Frequency 0	Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,621  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC data

Specialty Oto	Frequency 2316	Percentage 88.36 %
Specialty Gen Surg	Frequency 188	Percentage 7.17 %
Specialty	Frequency 0	Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Same as current code 42440

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value.

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
February and April 2008 – Initial Review

**Urological Procedures**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review several urological services (CPT codes 52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500, 53445, 54410, and 54530), the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVUs for each code. Two additional codes, 52640 and 57287 were also identified and addressed as part of the 4<sup>th</sup> Five-Year Review process (see October 2010 submission to CMS).

**52341, 52342, 52343, 52344, 52345, and 52346**

The six rarely performed cystourethroscopy codes (52341, 52342, 52343, 52344, 52345, and 52346) are all outpatient procedures with a 000 day global and no hospital discharge or visit work is included within the physician time for these services. The complexity of the services increase as the code numbers progress, however, the CMS proposed methodology does not recognize the clinical distinction of these services and creates rank order anomalies. The RUC reviewed the previous recommendations, which followed CMS basic premise and deducted any hospital visit work from the original valuation. The RUC review the relativity for the entire family of services and recommends that the 2010 values be maintained.

**The RUC recommends a work RVU of 5.35 for 52341, 5.85 for 52342, 6.55 for 52343, 7.05 for 52344, 7.55 for 52345, and 8.58 for 52346.**

**52400**

The RUC previously modified the post-operative work to concede that the service is reflected as an outpatient service in the Medicare population. However, the actual typical patient for this services is a pediatric patient and inpatient status may be typical for this patient population. The number of Medicare claims for this codes has decided as the specialty has educated their membership in the specific intent of this code. The 2010 work RVU of 8.69 for this service is dramatically lower than the 25% (13.75) and median (16.00) of the 2008 survey and the RUC, therefore, could not support any further decrease in the valuation of this service.

**The RUC recommends a work RVU of 8.69 for CPT Code 52400.**

**52500**

Despite a survey that supported the original valuation of 52500, the RUC deducted the hospital visit work from the valuation. The CMS “reverse building block” method results in a higher work RVU for this service, but neither the specialty or the RUC recommend that this method be used as a substitute for the RUC recommendation of 8.14.

**The RUC recommends a work RVU of 8.14 for 52500**

**53445**

The Medicare claims data indicate that 41% of these services are performed in the inpatient setting. The specialty argues that the typical patient spends at least one night in the hospital. The RUC has requested that the specialty survey to address whether an overnight stay is typical.

**The RUC recommends an interim work RVU of 15.39 and a survey addressing whether the service requires an overnight stay.**

**54410**

The Medicare claims data indicate that nearly 30% of these services are performed in the inpatient setting. The specialty argues that the typical patient spends at least one night in the hospital. The RUC has requested that the specialty survey to address whether an overnight stay is typical.

**The RUC recommends an interim work RVU of 15.18 and a survey addressing whether the service requires an overnight stay.**

**54530**

The specialty noted that this service should be typically reported for testicular tumors, which are rare in the Medicare population. The original survey supported an inpatient service and a value at least equivalent to the 2008 valuation. Nevertheless, the specialty and RUC did value the service as an outpatient service. The RUC supports its previous recommendation based on a comparison to other reference services. The RUC compared this service to codes 37650 *Ligation of femoral vein* (work RVU = 8.41, intra-service time = 60 minutes) and 53505 *Urethrorrhaphy, suture of urethral wound or injury; penile* (work RVU = 8.16, intra-service time = 59 minutes) to further support the recommendation of 8.46 for code 54530.

**The RUC recommends a work RVU of 8.46 for 54530.**

**February 2008 and April 2008 RUC Recommendations****52341**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 6.11). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52341 ( $6.11 - 0.76 = 5.35$ ) resulting in a work RVU of 5.35.

**52342**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 6.61). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52342 ( $6.61 - 0.76 = 5.85$ ) resulting in a work RVU of 5.85.

**52343**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 7.31). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52343 ( $7.31 - 0.76 = 6.55$ ) resulting in a work RVU of 6.55.

**52344**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52344 *Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 7.81). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52344 ( $7.81 - 0.76 = 7.05$ ) resulting in a work RVU of 7.05.

**52345**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 8.31). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52345 ( $8.31 - 0.76 = 7.55$ ) resulting in a work RVU of 7.55.

**52346**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 9.34). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52346 ( $9.34 - 0.76 = 8.58$ ) resulting in a work RVU of 8.58.

**52400**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (2008 work RVU = 10.06). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the physician work for half of a 99238 *Hospital discharge day management* (work RVU = 1.28) should be removed as well. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52400 ( $10.06 - 0.76 - 0.64 = 8.66$ ) resulting in a work RVU of 8.66 (8.69 in 2010).

**52500**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52500 *Transurethral resection of bladder neck (separate procedure)* (2008 work RVU = 9.39). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the 99238 *Hospital discharge day management* (work RVU = 1.28) should be reduced to a half discharge day. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52500 ( $9.39 - 0.76 - 0.64 = 7.99$ ) resulting in a work RVU of 7.99 (8.14 in 2010).

**53445**

In February 2008, the RUC discussed code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* and determined that it should be removed from the site-of-service screen and that the current work RVU of 15.21 be maintained. The specialty society indicated that although the Medicare data indicates this service is predominately performed in the outpatient setting (54% outpatient hospital and 45% inpatient hospital), survey respondents indicated this service is typically performed in the facility setting. The specialty society indicated that these patients typically have had a radical prostatectomy and are admitted for 24 hours in order to administer intravenous antibiotics and manage urethral catheters post-operatively. The RUC recommends maintaining the existing work RVU for 53445, however recommends using the new survey data for physician time and post-operative visits. The RUC recommends 1-99232, 1-99233, 1-99238, 1-99212, and 3-99213 post-operative visits. The RUC recommends removing this service from the site-of-service screen and recommends maintaining the work RVU of 15.21 for code 53445 (15.35 in 2010).

**54410**

In February 2008, the RUC reviewed specialty society survey results for code *54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* and determined that after removing the appropriate post-operative visits the surveyed 25<sup>th</sup> percentile work RVU of 15.00 was appropriate. The RUC recommends 1-99238, 1-99212 and 3-99213 post-operative visits for this service.

The RUC was compelled to maintain full discharge day management of the code based on the following information supplied by the specialty society. Although the CMS database has this procedure posted as being performed 32% as hospital inpatient and 67% as hospital outpatient, the majority of survey respondents reported a full discharge day and at least one hospital visit. The specialty society believes the discrepancy lies in coding of patients who remain in hospital for 23-hour stays. These patients undergo 30 minutes of immediate post-service care. The physician then rounds on them late in the day, and for most, the decision is made that the patient needs to stay in a monitored hospital setting overnight. The patients are then evaluated the next morning and discharged. A full discharge day management visit (99238) is required for this service because the typical patient goes home on the day after the service. Although the RUC may typically assign a half discharge day for outpatient services, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. The specialty society indicated that the typical patient for this service goes home the day after surgery, and the 99238 is the only visit assigned to the physician work on that day.

Additionally, the RUC determined that the survey pre-service evaluation time was slightly high compared to the pre-service evaluation time for reference service *54411 Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (pre-service evaluation = 50 minutes)* and other similar procedures. The RUC recommends pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes and pre-service scrub, dress, wait time of 15 minutes. The RUC recommends the 25<sup>th</sup> percentile work RVU of 15.00 (15.18 in 2010) for code 54410.

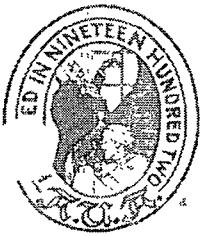
**54530**

In February 2008, the RUC reviewed and agreed with the specialty society survey recommendation for code 54530 *Orchiectomy, radical, for tumor; inguinal approach*. The survey median RVU was 10.38. However, since this service is predominantly performed in the hospital outpatient setting, the specialty society recommended and the RUC agreed to start with the survey median value of 10.38 and delete one 99323 visit, reduce the discharge day to a half-day and remove the associated RVUs with these post-operative visit deletions, ( $10.38 - 1.39 - 0.64 = 8.35$ ). The RUC recommends the surveyed physician times and a half day-99238, 2-99212 and 1-99213 post-operative visits.

Additionally, the RUC compared this service to codes 37650 *Ligation of femoral vein* (work RVU = 8.41, intra-service time = 60 minutes) and 53505 *Urethrorrhaphy, suture of urethral wound or injury; penile* (work RVU = 8.16, intra-service time = 59 minutes) to further support the recommendation of 8.35 (8.46 in 2010) for code 54530.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
51102	Aspiration of bladder; with insertion of suprapubic catheter	000	2.70  (no change)
52341	Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	5.35  (no change)
52342	Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	5.85  (no change)
52343	Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	6.55  (no change)

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.05  (no change)
52345	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.55  (no change)
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	8.58  (no change)
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	090	8.69  (no change)
52500	Transurethral resection of bladder neck (separate procedure)	090	8.14  (no change)
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	090	15.39  (no change)
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	090	15.18  (no change)
54530	Orchiectomy, radical, for tumor; inguinal approach	090	8.46  (no change)



# American Urological Association

August 16, 2010

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Relative Value Update Committee  
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Re: Requested response to CMS from AUA to Review of CPT Codes for Site of Service Anomalies

Dear Dr. Levy,

For the October 2010 RUC meeting, the RUC has requested that the AUA review for 13 CPT codes in the urology section of CPT as having a "site of service anomaly." This is done at the request of CMS which questions the methodology used in determining the RVU work values based on calculations using the building block method consistently used by the RUC.

### Comment on Proposed CMS Methodology:

The justification for this methodology is stated by CMS in the 2011 Proposed Rule CMS-1503 on p113:

"If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both."

This assumption is flawed. It is not "reasonable to expect" that physician time and intensity have decreased. When a procedure migrates from inpatient to outpatient setting the physician work and practice expense do change; physician work previously performed in the hospital in the post operative period shifts to the office (it does not decrease) and the practice expense increases as the supplies and equipment necessary for post operative care are now provided by the physician office. As a result the cost to the hospital decreases as the "site-of-service" for post operative care shifts to the physician office. The result is more office visits, more utilization of office staff, more consumption of office supplies and no decrease in legal liability to the physician (and in some instances, increased legal liability as functions formerly performed by hospital staff are now done by physician office staff). The rigorous RUC methodology recognizes and appropriately changes (increases or decreases) RVUs as was done with the codes under question in 2008.



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In addition the proposed CMS methodology creates rank order anomalies assigning lower RVUs to more difficult procedures and higher RVUs to less difficult procedures.

**TABLE 15: CY 2009 Site-of-Service Anomaly Codes**

CPT Code	Short Descriptor	CY 2008 RVUs ("Starting Value")	RUC Recommended Value for CY 2009	CY 2011 Reverse Building Block Value
52341	Cysto w/ureter stricture tx	6.11	5.35	5.62
52342	Cysto w/up stricture tx	6.61	5.85	6.20
52343	Cysto w/renal stricture tx	7.31	6.55	5.90
52344	Cysto/uretero, stricture tx	7.81	7.05	5.58
52345	Cysto/uretero w/up stricture	8.31	7.55	5.76
52346	Cystouretero w/renal strict	9.34	8.58	6.05
52400	Cystouretero w/congen repr	10.06	8.66	7.00
52500	Revision of bladder neck	9.39	7.99	8.72
52640	Relieve bladder contracture	6.89	4.73	5.01
53445	Insert uro/ves nck sphincter	15.21	15.21	11.72
54410	Remove/replace penis prosth	16.48	15.00	14.00
54530	Removal of testis	9.31	8.35	8.88
57287	Revise/remove sling repair	11.49	10.97	10.20

The urological procedures were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for these code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated because they are potentially misvalued.

At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs until April 2008 to allow specialty societies to conform to these rules and alter their recommendations as necessary.

The AUA RUC physician panel reviewed the recommendations approved by the RUC at the April 2008 and still agrees with the removal of the RVUs for any associated hospital visit and appropriate discharge day management codes. The RUC has a rigorous review process for codes identified in any screen and requires a complete and data driven explanation for the recommendation from any specialty society. The AUA contends that the RUC recommendations should remain appropriate for all the codes listed in this letter and will be outlined below. The values address any rank order anomaly and remain appropriate as presented at the April 2008 RUC meeting.

At the February 2008 RUC meeting, the AUA presented survey data due to site of service anomalies on the identified codes. Since there was confusion, the AUA was able to submit further recommendations for the April 2008 RUC meeting. At the time, the AUA used a reverse building block method and removed the RVUs for hospital visits for procedures being performed in the office or outpatient setting. All RVUs for associated hospital visits have been removed. All 90 day global procedures, however, were granted a half day discharge for procedures performed in the outpatient setting. The appropriate discharge day RVUs were also removed.

There was also a question on codes that required a patient stay up to 23 hours in observation status and not admitted to the hospital which remains unanswered by the RUC. This applies to CPT 53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff and 54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session.

**CPT 52341, 52342, 52343, 52344, 52345 and 52346** (a "family" of related codes):

Codes that describe treatment of ureteral, ureteral-pelvic junction and intra-renal strictures.

**52341 Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a **99231 Subsequent hospital care visit (work RVU = 0.76) should be removed**. The RUC deleted the value of a 99231 visit from the current value for code 52341 ( $6.11 - 0.76 = 5.35$ ) resulting in a work RVU of 5.35. The RUC recommends a work RVU of 5.35 and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 55 min/Scrub/Prep 15 min/Intraservice 45 min/Post service 20 min) for code 52341.

**52342 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a **99231 Subsequent hospital care visit (work RVU = 0.76)** should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52342 ( $6.61 - 0.76 = 5.85$ ) resulting in a work RVU of 5.85. The RUC recommends a work RVU and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 50 min/Scrub/Prep 10 min/Intraservice 60 min/Post service 20 min) of 5.85 for code 52342.

**52343 Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a **99231 Subsequent hospital care visit (work RVU = 0.76)** should be removed. The RUC deleted the value of a **99231** visit from the current value for code 52343 ( $7.31 - 0.76 = 6.55$ ) resulting in a work RVU of 6.55. The RUC recommends a work RVU of 6.55 and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 55 min/Scrub/Prep 10 min/Intraservice 60 min/Post service 25 min)for code 52343.

**52344 Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a **99231 Subsequent hospital care visit (work RVU = 0.76)** should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52344 ( $7.81 - 0.76 = 7.05$ ) resulting in a work RVU of 7.05. The RUC recommends a work RVU of 7.05 and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 50 min/Scrub/Prep 10 min/Intraservice 45 min/Post service 20 min)for code 52344.

**52345 Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a **99231 Subsequent hospital care visit (work RVU = 0.76)** should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52345 ( $8.31 - 0.76 = 7.55$ ) resulting in a work RVU of 7.55. The RUC recommends a work RVU of 7.55 and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 55 min/Scrub/Prep 15 min/Intraservice 45 min/Post service 20 min) for code 52345.

**52346 Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a **99231 Subsequent hospital care visit (work RVU = 0.76)** should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52346 ( $9.34 - 0.76 = 8.58$ ) resulting in a work RVU of 8.58. The RUC recommends a work RVU of 8.58 and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 50 min/Scrub/Prep 10 min/Intraservice 60 min/Post service 20 min) for code 52346.

**CPT 52400 Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds**

This is a pediatric code and describes the treatment of "urethral valves" in newborn and infants males. This is a pediatric procedure, not an adult procedure. The vignette states: A 2-month-old boy presents with a poor urinary stream, palpable bladder, and elevated serum creatinine. He has severe vesicoureteral reflux secondary to congenital urethral valves.

The AUA RUC panel reviewed this code and believes that there was a misunderstanding by the survey respondents. This survey was sent to a random list of urologists and was not targeted to a panel of pediatric urologists who perform this procedure.

Although the information in the RUC Medicare Claims database indicates that 56% of patients undergoing this procedure were over age 75, AUA feels this is due to incorrect or erroneous billing. The AUA has been trying to educate its members with some success in this regard. In 1998 this code was billed to Medicare 3,383 times and in 2008 only 635 times. In conversations with leaders of the Society for Pediatric Urology (SPU), they state that these infants are usually in renal failure from chronic urinary retention due to the obstruction of the bladder outlet by the urethral valves. These patients are often in the hospital for a number of days and are managed in conjunction with pediatricians and pediatric nephrologists. The Medicare data base should be ignored in this instance due to the fact that this is a pediatric procedure, not an outpatient procedure and not performed on the Medicare population.

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a **99231 Subsequent hospital care visit (work RVU = 0.76)** should be removed and the physician work for half of a **99238 Hospital discharge day management (work RVU = 1.28)** should be removed as well. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52400 ( $10.06 - 0.76 - 0.64 = 8.66$ ) resulting in a work RVU of 8.66. The RUC recommends a work RVU of 8.66 and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 82.5 min/Scrub/Prep 15 min/Intraservice 40 min/Post service 25 min) for code 52400.

AUA feels that the current RVW of 8.66 is inappropriately low and that the previous value of 10.06 more appropriately reflects the difficulty, intensity and skill as well as post op management of these challenging patients.

**CPT 52500 Transurethral resection of bladder neck (separate procedure).**

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the 99238 *Hospital discharge day management* (work RVU = 1.28) should be reduced to a half discharge day. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52500 ( $9.39 - 0.76 - 0.64 = 7.99$ ) resulting in a work RVU of 7.99. The RUC recommends a work RVU of 7.99 and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 55 min/Scrub/Prep 15 min/Intraservice 45 min/Post service 27.5 min) for code 52500.

**CPT 52640 Transurethral resection; of postoperative bladder neck contracture.**

The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of any 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the 99238 *Hospital discharge day management* (work RVU = 1.28) should be reduced to a half discharge day. The RUC deleted the value of two 99231 visits and deleted the value for half a discharge day management from the current value for code 52640 ( $6.89 - 0.76 - 0.76 - 0.64 = 4.73$ ) resulting in a work RVU of 4.73. The RUC recommends a work RVU of 4.73 and the specialty society surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 50 min/Scrub/Prep 10 min/Intraservice 30 min/Post service 20 min) for code 52640.

This code has also been identified for the Fourth Five Year Review and the AUA will present the Summary of Recommendations at the September/October 2010 RUC meeting.

**CPT 53445 Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff**

In February 2008, the RUC discussed code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* and determined that it should be removed from the site-of-service screen and that the current work RVU of 15.21 be maintained. The specialty society indicated that although the Medicare data indicates this service is predominately performed in the outpatient setting (54% outpatient hospital and 45% inpatient hospital), survey respondents indicated this service is typically performed in the facility setting. The specialty society indicated that these patients typically have had a radical prostatectomy and are admitted for 24 hours in order to administer intravenous antibiotics and manage urethral catheters post-operatively. The RUC recommends maintaining the existing work RVU for 53445, however recommends using the new survey data for physician time (Prior day Evaluation

0 min/Same Day Evaluation 65 min/Scrub/Prep 20 min/Intraservice 90 min/Post service 25 min) and post-operative visits. The RUC recommends 1-99232, 1-99233, 1-99238, 1-99212, and 3-99213 post-operative visits. The RUC recommends removing this service from the site-of-service screen and recommends maintaining the work RVU of 15.21 for code 53445.

**CPT 54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session**

In February 2008, the RUC reviewed specialty society survey results for code 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* and determined that after removing the appropriate post-operative visits the surveyed 25<sup>th</sup> percentile work RVU of 15.00 was appropriate. The RUC recommends 1-99238, 1-99212 and 3-99213 post-operative visits for this service.

The RUC was compelled to maintain full discharge day management of the code based on the following information supplied by the specialty society. Although the CMS database has this procedure posted as being performed 32% as hospital inpatient and 67% as hospital outpatient, the majority of survey respondents reported a full discharge day and at least one hospital visit. The specialty society believes the discrepancy lies in coding of patients who remain in hospital for 23-hour stays. These patients undergo 30 minutes of immediate post-service care. The physician then rounds on them late in the day, and for most, the decision is made that the patient needs to stay in a monitored hospital setting overnight. The patients are then evaluated the next morning and discharged. A full discharge day management visit (99238) is required for this service because the typical patient goes home on the day after the service. Although the RUC may typically assign a half discharge day for outpatient services, the RUC stated very clearly that if a full discharge day is justified, it can and should be assigned. The specialty society indicated that the typical patient for this service goes home the day after surgery, and the 99238 is the only visit assigned to the physician work on that day.

Additionally, the RUC determined that the survey pre-service evaluation time was slightly high compared to the pre-service evaluation time for reference service 54411 *Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue (pre-service evaluation = 50 minutes)* and other similar procedures. The RUC recommends pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes and pre-service scrub, dress, wait time of 15 minutes. The RUC recommends the 25<sup>th</sup> percentile work RVU of 15.00 for code 54410.

**CPT 54530 Orchiectomy, radical, for tumor; inguinal approach**

Of note this is a procedure performed in young men typically between the age of 18 and 35. *Testicular tumors in the Medicare population are extremely rare and the Medicare billing data indicating 1,426 performed in 2008 are questionable.*

In February 2008, the RUC reviewed and agreed with the specialty society survey recommendation for code 54530 *Orchiectomy, radical, for tumor; inguinal approach*. The survey median RVU was 10.38. However, since this service is predominantly performed in the hospital outpatient setting, the specialty society recommended and the RUC agreed to start with the survey median value of 10.38 and delete one 99323 visit, reduce the discharge day to a half-day and remove the associated RVUs with these post-operative visit deletions, ( $10.38 - 1.39 - 0.64 = 8.35$ ). The RUC recommends the surveyed physician times (Prior day Evaluation 0 min/Same Day Evaluation 50 min/Scrub/Prep 10 min/Intraservice 60 min/Post service 20 min) and a half day-99238, 2-99212 and 1-99213 post-operative visits.

Additionally, the RUC compared this service to codes 37650 *Ligation of femoral vein* (work RVU = 8.41, intra-service time = 60 minutes) and 53505 *Urethrorrhaphy, suture of urethral wound or injury; penile* (work RVU = 8.16, intra-service time = 59 minutes) to further support the recommendation of 8.35 for code 54530. The RUC recommends a work RVU of 8.35 for code 54530.

#### **57287 Removal or revision of sling for stress incontinence (eg, fascia or synthetic)**

The RUC reviewed the pre-service times and immediate post-service physician times. The RUC determined that the survey respondents over-estimated the pre- and immediate post-service times as they indicated significantly higher times compared to the current physician time associated with this service and physician times for similar services. The RUC recommends 40 minutes pre-evaluation, 10 minutes pre-positioning, 10 minutes scrub, dress, wait time and 20 minutes immediate post-service time (intraservice 60 min).

The survey median RVU for 57287 was 13.00. However, since this service is predominantly performed in the hospital outpatient setting, the specialty society recommended starting with the survey median of 13.00 and delete one 99323 visit, reduce the discharge day to a half-day and remove the associated RVUs with these post-operative visit deletions, ( $13.00 - 1.39 - 0.64 = 10.97$ ). The RUC recommends a half day 99238, 1-99212 and 3-99213 post-operative visits.

Additionally, the RUC compared this service to code 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU = 10.68, intra-service time = 58 minutes) as a reference to further support the recommendation of 10.97 for code 57287. The RUC recommends a work RVU of 10.97 for code 57287.

This code has also been identified for the Fourth Five Year Review and the AUA will present the Summary of Recommendations at the September/October 2010 RUC meeting.

The AUA supports the recommendations of the RUC that these codes were valued appropriately using the building block or reverse building block to value codes with site of service anomalies.

Sincerely,

A handwritten signature in black ink, appearing to read "Datta G. Wagle".

Datta G. Wagle, M.D.  
President  
American Urological Association

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review	
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75				75	120	43	2	2	2	1	1	1	1	428	0.0145		Pre-RUC Evaluation		
		10.03	2010	1,123	60	10	15	85	90	30	2	2						283	0.0530	AAOMS	Post-RUC Evaluation		
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49				49	62	23	3.5		0.5	1	1	1	1	238	0.0886		Pre-RUC Evaluation		
		9.23	2010	1,237	40	15	15	70	60	20	2.0	2.0			0.5	0.5	0.5	247	0.0648	AAOS	Post-RUC Evaluation		
25116	REMOVE WRIST/FOREARM LESION	7.38	2009	36				36	78	21	5.0		1.5		1.0	1.0	1.0	1.0	283	0.0192		Pre-RUC Evaluation	
		7.56	2010	1,030	40	10	15	65	60	20	1.0	3.0			0.5	0.5	0.5	0.5	249	0.0307	ASSH, AAOS, ASPS	Post-RUC Evaluation	
27792	TREATMENT OF ANKLE FRACTURE	7.91	2007	21		25		83	19	4.0		1.5		1.0								Pre-RUC Evaluation	
		9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0	1.0	1.0	1.0	1.0	1.0	281	0.0513	AAOS, AOFAS	Post-RUC Evaluation		
28120	PART REMOVAL OF ANKLE/HEEL	5.64	2009	47				47	67	21	3.5		1.5	1.0	1.0	1.0	1.0	259	0.0056		Pre-RUC Evaluation		
		8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0	1.0	1.0	1.0	1.0	1.0	280	0.0263	AAOS, APMA	Post-RUC Evaluation		
		7.56	2009	43				43	51	26	5.0		1.5	1.0	1.0	1.0	1.0	268	0.0304		Pre-RUC Evaluation		
28122	PARTIAL REMOVAL OF FOOT BONE	7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0	1.0	1.0	1.0	1.0	1.0	264	0.0249	AAOS, APMA	Post-RUC Evaluation		
		11.97	2009	50				50	89	22	4.0		2.5		1.0	1.0	1.0	1.0	313	0.0631		Pre-RUC Evaluation	
28725	FUSION OF FOOT BONES	12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0	1.0	1.0	1.0	1.0	339	0.0496	AAOS	Post-RUC Evaluation		
		12.21	2009	60				60	120			5.0	1.0		1.0	1.0	1.0	1.0	383	0.0331		Pre-RUC Evaluation	
28730	FUSION OF FOOT BONES	12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0	1.0	1.0	1.0	1.0	349	0.0471	AAOS	Post-RUC Evaluation		
		3.71	2008	17				25	42	36	16	3.5		0.5		1.0	1.0	1.0	1.0	198	0.0151		Pre-RUC Evaluation
28825	PARTIAL AMPUTATION OF TOE	6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0			1.0	1.0	1.0	1.0	224	0.0099	AAOS	Post-RUC Evaluation	
		9.15	2008	29				25	54	75	28	2.5		1.5	1.0	1.0	1.0	265	0.0540		Pre-RUC Evaluation		
36821	AV FUSION DIRECT ANY SITE	12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0			1.0	1.0	1.0	1.0	256	0.0823	ACS, SVS, RPA	Post-RUC Evaluation	
		10.00	2009	56				56	81	22	2.5		1.0	1.0	1.0	1.0	1.0	257	0.0663		Pre-RUC Evaluation		
36825	ARTERY-VEIN AUTOGRAPH	15.13	2010	4,873	40	10	20	70	120	30	1.0	2.0	1.0	1.0	1.0	1.0	1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation		
		17.99	2009	55				55	156	37	3.5		1.5	1.0	1.0	1.0	1.0	396.5	0.0671		Pre-RUC Evaluation		
42415	EXCISE PARTOID GLAD/LESION	18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0			1.0	1.0	1.0	1.0	342	0.0843	ACS, AAO-HNS	Post-RUC Evaluation	
		20.87	2009	57				57	182	22	3.5		3.0	1.0	1.0	1.0	1.0	349.5	0.0687		Pre-RUC Evaluation		
42420	EXCISE PARTOID GLAD/LESION	21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0	1.0	1.0	1.0	1.0	432	0.0743	ACS, AAO-HNS	Post-RUC Evaluation		
		7.05	2009	47				47	71	19	1.5		0.5	1.0	1.0	1.0	1.0	209	0.0500		Pre-RUC Evaluation		
42440	EXCISE SUBMAXILLARY GLAND	7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0			0.5	1.0	1.0	1.0	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation	
		9.97	2009	45				45	67.5	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	239.5	0.0711		Pre-RUC Evaluation	
49507	PRP I/HERN INIT BLOCK >5YR	10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	260	0.0680	ACS	Post-RUC Evaluation	
		12.36	2009	45				45	90	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	262	0.0799		Pre-RUC Evaluation	
49521	REREPAIR ING HERNIA, BLOCKED	12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	280	0.0795	ACS	Post-RUC Evaluation	
		7.96	2009	45				45	60	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	232	0.0465		Pre-RUC Evaluation	
49587	RPR UNBIL HERN, BLOCK >5YR	8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	250	0.0459	ACS	Post-RUC Evaluation	
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010	1	45	15	15	75	90	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	292	0.0806	ACS	New Code in 2009	
49653	LAP VENT/ABD HERN-PROC COMP.	16.21	2010	1	45	15	15	75	120	30	2.0	1.0	1.0		1.0	1.0	1.0	1.0	378	0.0726	ACS	New Code in 2009	
49654	LAP INC HERNIA REPAIR	15.03	2010	1	45	15	15	75	120	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	362	0.0668	ACS	New Code in 2009	
49655	LAP INC HERN REPAIR COMP	18.11	2010	1	50	15	15	80	150	30	2.0	1.0	1.0		1.0	1.0	1.0	1.0	413	0.0700	ACS	New Code in 2009	
		6.11	2008	47.5				47.5	60	49								156.5	0.0658		Pre-RUC Evaluation		
52341	CYSTO W/URETER STRICTURE TX	5.35	2010	2,105	45	10	15	70	45	20								135	0.0789	AUA	Post-RUC Evaluation		
		6.61	2008	60				60	65	30			1.0					175	0.0590		Pre-RUC Evaluation		
52342	CYSTO W/UP STRICTURE TX	5.85	2010	281	40	10	10	60	60	20								140	0.0700	AUA	Post-RUC Evaluation		
		7.31	2008	60				60	90	30			1.0					200	0.0504		Pre-RUC Evaluation		
52343	CYSTO W/RENAL STRICTURE TX	6.55	2010	37	45	10	10	65	60	25								150	0.0780	AUA	Post-RUC Evaluation		
		7.81	2008	60				60	77.5	30			1.0					187.5	0.0650		Pre-RUC Evaluation		
52344	CYSTO/URETERO, STRICTURE TX	7.05	2010	2,447	40	10	10	60	45	20								125	0.1200	AUA	Post-RUC Evaluation		
		8.31	2008	50				50	90	30			1.0					190	0.0640		Pre-RUC Evaluation		
52345	CYSTO/URETERO W/UP STRICTURE	7.55	2010	475	45	10	15	70	45	20								135	0.1277	AUA	Post-RUC Evaluation		
		9.34	2008	45				45	120	49								214	0.0603		Pre-RUC Evaluation		
52346	CYSTOURERETO W/RENAL STRICT	8.58	2010	144	40	10	10	60	60	20								140	0.1155	AUA	Post-RUC Evaluation		
		10.06	2008	90				90	60	30		1.0	1.0		1.0			261	0.0727		Pre-RUC Evaluation		
52400	CYSTOURERETO W/CONGEN REPR	8.69	2010	635	72.5	10	15	97.5	40	25	1.0		1.0		0.5	1.0	1.0	197.5	0.1260	AUA	Post-RUC Evaluation		
		9.39	2008	40				40	45	35			3.0		1.0	1.0	1.0	247	0.0613		Pre-RUC Evaluation		
52500	REVISION OF BLADDER NECK	8.14	2010	5,348	45	10	15	70	45	27.5			3.0		1.0	1.0	1.0	230.5	0.0582	AUA	Post-RUC Evaluation		
		6.89	2008	50				50	39	17			2.0		1.0	1.0	1.0	218	0.0569		Pre-RUC Evaluation		
52640	RELIEVE BLAD CONTRA	4.79	2010	2,217	40	10	10	60	30	20			1.0		0.5	1.0	1.0	161	0.0514	AUA	RUC Evaluation		

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWP/UT	Specialty Societies	Review	
											15.21	2009	75	15	20	85	90	126	24	3.0	3.0	1.0	1.0
53445	INSERT URO/VES NCK SPHINCTER	15.39	2010	1,949	50	15	20	85	90	145	30	25	1.0	3.0	1.0	1.0	1.0	1.0	1.0	418	0.0572	AUA	Post-RUC Evaluation
54410	REMOVE/REPLACE PENIS PROSTH	16.48	2008	50	10	10	15	50	120	30	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	369	0.0635	Pre-RUC Evaluation	
54530	REMOVAL OF TESTIS	9.31	2008	58	10	15	58	58	17	2.5	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	238.5	0.0673	Pre-RUC Evaluation	
		8.46	2010	1,426	57.5	10	15	82.5	60	30	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	246.5	0.0597	AUA	Post-RUC Evaluation
57287	REVISE/REMOVE SLING REPAIR	11.49	2008	45	10	10	10	45	60	30	1.0	2.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	285	0.0656	Pre-RUC Evaluation	
		11.15	2010	1,795	40	10	10	60	60	20	1.0	3.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	244	0.0912	AUA, ACOG	Post-RUC Evaluation
		7.37	2009		50			50	60	25	4.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	325	-0.027		Pre-RUC Evaluation
61865	INSRT/REDO NEUROSTIM I ARRAY	6.44	2010	4,358	53	13	15	51	45	20	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	181	0.0567	AANS/CNS	Post-RUC Evaluation
		6.41	2009		40			40	30	20	2.0	2.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	200	0.0435		Pre-RUC Evaluation
62263	EPIDURAL LYSIS MULT SESSIONS	6.54	2010	1,269	33	10	5	48	45	20	1.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation
		8.04	2008		70			70	60	125	4.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	487	-0.0715		Pre-RUC Evaluation
62350	IMPLANT SPINAL CANAL CATH	6.05	2010	6,416	33	10	5	48	60	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation
		6.60	2008		60			60	40	130	3.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	446	-0.1284		Pre-RUC Evaluation
62355	REMOVE SPINAL CANAL CATHETER	4.35	2010	1,461	33	10	5	48	30	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation
		3.68	2008		60			60	55	123	4.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	450	-0.1385		Pre-RUC Evaluation
62360	INSERT SPINE INFUSION DEVICE	4.33	2010	616	33	10	5	48	60	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	170	0.0211	AAPMR, ASA, NASS, APM, AANS/CNS	Post-RUC Evaluation
		6.59	2008		60			60	60	130	4.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	482	-0.0938		Pre-RUC Evaluation
62361	IMPLANT SPINE INFUSION PUMP	5.65	2010	307	33	10	5	48	60	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation
		8.58	2008		75			75	90	150	4.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	582	-0.0629		Pre-RUC Evaluation
62362	IMPLANT SPINE INFUSION PUMP	6.10	2010	6,570	33	10	5	48	60	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation
		6.57	2008		60			60	45	125	3.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	446	-0.1123		Pre-RUC Evaluation
62365	REMOVE SPONE INFUSION DEVICE	4.65	2010	1,598	33	10	5	48	45	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	155	0.0353	AAPMR, ASA, NASS, APM, AANS/CNS	Post-RUC Evaluation
		7.57	2008		56			56	74	19	2.0	2.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	283	0.0152		Pre-RUC Evaluation
63650	IMPLANT NEUROELECTRODES	7.20	2010	31,144	33	10	5	48	60	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation
		7.87	2008		53			53	62	18	2.0	2.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	267	0.0245		Pre-RUC Evaluation
63685	INSRT/REDO SPINE N GENERATOR	6.05	2010	9,343	33	10	5	48	60	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation
		6.22	2009		46			46	76	18	2.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	228	0.0301		Pre-RUC Evaluation
64708	REVISE ARM/LEG NERVE	6.36	2010	3,069	35	10	10	55	60	15	3.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	220	0.0314	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation
		10.23	2008		50			50	74	21	2.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	260.5	0.0612		Pre-RUC Evaluation
64831	REPAIR OF DIGIT NERVE	9.16	2010	972	40	10	15	65	60	15	2.0	2.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation
65285	REPAIR OF EYE WOUND	14.43	2009	52	37			15	52	79	32	5.5	0.5	1.0	1.0	1.0	1.0	1.0	1.0	337.5	0.0730		Pre-RUC Evaluation
		14.71	2010	1,154	37			15	52	79	32	5.5	0.5	1.0	1.0	1.0	1.0	1.0	1.0	337.5	0.0766	AAO	Post-RUC Evaluation

Codes to be reviewed on the Fourth Five-Year Review Agenda (52640 and 57287) and recent May 2010 Submission (61865)

23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values

\*2010 Post- RUC Review work RVVs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11179 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 6177). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).
- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs)	1 visit (1.28 RVUs)	2 visits (0.36 RVUs).	2 visits (0.96 RVUs)	2 visits (1.94 RVUs)	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0 0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	-0.44 RVUs	0.38 RVUs ...	-0.76 RVUs	-1.39 RVUs	-0.64 RVUs	-0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39)$

$$- 0.64 - 0.36 = 8.08$$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insr/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Prp umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insr/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IPUT is counterintuitive to the IPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February and April 2008

**Urological Procedures**

The following urological procedures were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for these code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated because they are potentially misvalued.

**51102 (renumbered, previously code 51010)**

At the February 2008 meeting the RUC reviewed the specialty society recommendation for code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* and determined that the vignette may have misled survey respondents to inappropriately conclude there are certain post-operative visits because it included "is admitted to the ICU". The RUC also determined that this service should have a 000-day global period instead of a 010-day global period because the post-operative period is variable, meaning there is no typical standard regarding the number post-operative office visits. The RUC requested that CMS assign a 000-day global period to code 51102 and that the specialty society resurvey this service with the revised vignette. CMS notified the RUC that a 000-day global period would be acceptable.

In April 2008, the RUC reviewed the new survey results and specialty society recommendation for code 51102 and determined that the pre-service time package 1B – straightforward patient procedure (w/sedation/anesthesia) of 25 minutes, the survey intra-service time of 20 minutes and the survey immediate post-service time of 15 minutes appropriately demonstrated the physician time required to perform this procedure. The RUC determined that the specialty society's survey 25<sup>th</sup> percentile work RVU of 2.70 appropriately accounted for the intensity and complexity of physician work required to perform this 000-day global procedure. The RUC also compared code 51102 to a similar service, code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU=2.50, 25 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and determined that 51102 work RVU was slightly higher as a longer intra-service and immediate post-service time is required to perform this procedure. **The RUC recommends the specialty society's survey 25<sup>th</sup> percentile work RVU of 2.70 for code 51102.**

### **52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500, 52640 and 54405**

At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly. The RUC deferred consideration of all recommendations for increases to work RVUs until April 2008 to allow specialty societies to conform to these rules and alter their recommendations as necessary. The following codes were then reviewed at the April 2008 RUC meeting: 52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500, 52640 and 54405. In April, the specialty society indicated that compelling evidence would not be provided to increase the valuation of these services. The specialty recommended that the work of previously indicated hospital visits would be removed.

#### **52341**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 6.11). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52341 ( $6.11 - 0.76 = 5.35$ ) resulting in a work RVU of 5.35. **The RUC recommends a work RVU of 5.35 and the specialty society surveyed physician times for code 52341.**

#### **52342**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 6.61). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52342 ( $6.61 - 0.76 = 5.85$ ) resulting in a work RVU of 5.85. **The RUC recommends a work RVU and the specialty society surveyed physician times of 5.85 for code 52342.**

#### **52343**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52343 *Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 7.31). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76)

should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52343 ( $7.31-0.76 = 6.55$ ) resulting in a work RVU of 6.55. **The RUC recommends a work RVU of 6.55 and the specialty society surveyed physician times for code 52343.**

#### **52344**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52344 *Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 7.81). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52344 ( $7.81-0.76 = 7.05$ ) resulting in a work RVU of 7.05. **The RUC recommends a work RVU of 7.05 and the specialty society surveyed physician times for code 52344.**

#### **52345**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 8.31). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52345 ( $8.31-0.76 = 7.55$ ) resulting in a work RVU of 7.55. **The RUC recommends a work RVU of 7.55 and the specialty society surveyed physician times for code 52345.**

#### **52346**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52346 *Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)* (2008 work RVU = 9.34). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed. The RUC deleted the value of a 99231 visit from the current value for code 52346 ( $9.34-0.76 = 8.58$ ) resulting in a work RVU of 8.58. **The RUC recommends a work RVU of 8.58 and the specialty society surveyed physician times for code 52346.**

#### **52400**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52400 *Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds* (2008 work RVU = 10.06). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the physician work for half of a 99238 *Hospital discharge day management* (work RVU = 1.28) should be removed as well. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52400 ( $10.06 - 0.76 - 0.64 = 8.66$ ) resulting in a work RVU of 8.66. **The RUC recommends a work RVU of 8.66 and the specialty society surveyed physician times for code 52400.**

#### **52500**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52500 *Transurethral resection of bladder neck (separate procedure)* (2008 work RVU = 9.39). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of a 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the 99238 *Hospital discharge day management* (work RVU = 1.28) should be reduced to a half discharge day. The RUC deleted the value of a 99231 visit and deleted the value for half a discharge day management from the current value for code 52500 ( $9.39 - 0.76 - 0.64 = 7.99$ ) resulting in a work RVU of 7.99. **The RUC recommends a work RVU of 7.99 and the specialty society surveyed physician times for code 52500.**

#### **52640**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 52640 *Transurethral resection; of postoperative bladder neck contracture* (2008 work RVU = 6.89). The specialty society recommended and the RUC agreed that since this service is typically performed in an outpatient setting, the physician work value of any 99231 *Subsequent hospital care visit* (work RVU = 0.76) should be removed and the 99238 *Hospital discharge day management* (work RVU = 1.28) should be reduced to a half discharge day. The RUC deleted the value of two 99231 visits and deleted the value for half a discharge day management from the current value for code 52640 ( $6.89 - 0.76 - 0.64 = 4.73$ ) resulting in a work RVU of 4.73. **The RUC recommends a work RVU of 4.73 and the specialty society surveyed physician times for code 52640.**

#### **54405**

In April 2008, the RUC received notification that the specialty society determined that there was not sufficient evidence to support an increase in RVUs for code 54405 *Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, CPT five-digit codes, two-digit modifiers, and descriptions only* are copyright by the American Medical Association.

*and reservoir* (2008 work RVU = 14.39). The specialty society indicated that this service is a 23-hour stay that usually requires patients to spend at least one night in the hospital. The specialty society requested that review of code 54405 be deferred until after the RUC develops the specific 23 hour service survey instrument and/or a process to address these 23-hour services. **The RUC recommends that the current work RVU of 14.39 and physician times for code 54405 be maintained and that the specialty society resurvey this code after the development of the process to handle specific 23 hour services.**

#### **53445**

In February 2008, the RUC discussed code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* and determined that it should be removed from the site-of-service screen and that the current work RVU of 15.21 be maintained. The specialty society indicated that although the Medicare data indicates this service is predominately performed in the outpatient setting (54% outpatient hospital and 45% inpatient hospital), survey respondents indicated this service is typically performed in the facility setting. The specialty society indicated that these patients typically have had a radical prostatectomy and are admitted for 24 hours in order to administer intravenous antibiotics and manage urethral catheters post-operatively. The RUC recommends maintaining the existing work RVU for 53445, however recommends using the new survey data for physician time and post-operative visits. The RUC recommends 1-99232, 1-99233, 1-99238, 1-99212, and 3-99213 post-operative visits. **The RUC recommends removing this service from the site-of-service screen and recommends maintaining the work RVU of 15.21 for code 53445.**

#### **54410**

In February 2008, the RUC reviewed specialty society survey results for code 54410 *Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session* and determined that after removing the appropriate post-operative visits the surveyed 25<sup>th</sup> percentile work RVU of 15.00 was appropriate. The RUC recommends 1-99238, 1-99212 and 3-99213 post-operative visits for this service.

The RUC was compelled to maintain full discharge day management of the code based on the following information supplied by the specialty society. Although the CMS database has this procedure posted as being performed 32% as hospital inpatient and 67% as hospital outpatient, the majority of survey respondents reported a full discharge day and at least one hospital visit. The specialty society believes the discrepancy lies in coding of patients who remain in hospital for 23-hour stays. These patients undergo 30 minutes of immediate post-service care. The physician then rounds on them late in the day, and for most, the decision is made that the patient needs to stay in a monitored hospital setting overnight. The patients are then evaluated the next morning and discharged. A full discharge day management visit (99238) is required for this service because the typical patient goes home on the day after the service. Although the RUC may typically assign a half discharge day for outpatient services, the RUC stated very clearly that if a full discharge day is justified,

it can and should be assigned. The specialty society indicated that the typical patient for this service goes home the day after surgery, and the 99238 is the only visit assigned to the physician work on that day.

Additionally, the RUC determined that the survey pre-service evaluation time was slightly high compared to the pre-service evaluation time for reference service *54411 Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue* (pre-service evaluation = 50 minutes) and other similar procedures. The RUC recommends pre-service evaluation time of 40 minutes, pre-service positioning time of 10 minutes and pre-service scrub, dress, wait time of 15 minutes. **The RUC recommends the 25<sup>th</sup> percentile work RVU of 15.00 for code 54410.**

#### **54530**

In February 2008, the RUC reviewed and agreed with the specialty society survey recommendation for code *54530 Orchietomy, radical, for tumor; inguinal approach*. The survey median RVU was 10.38. However, since this service is predominantly performed in the hospital outpatient setting, the specialty society recommended and the RUC agreed to start with the survey median value of 10.38 and delete one 99323 visit, reduce the discharge day to a half-day and remove the associated RVUs with these post-operative visit deletions, ( $10.38 - 1.39 - 0.64 = 8.35$ ). The RUC recommends the surveyed physician times and a half day-99238, 2-99212 and 1-99213 post-operative visits.

Additionally, the RUC compared this service to codes *37650 Ligation of femoral vein* (work RVU = 8.41, intra-service time = 60 minutes) and *53505 Urethrorrhaphy, suture of urethral wound or injury; penile* (work RVU = 8.16, intra-service time = 59 minutes) to further support the recommendation of 8.35 for code 54530. **The RUC recommends a work RVU of 8.35 for code 54530.**

#### **57287**

In February 2008, the RUC reviewed code *57287 Removal or revision of sling for stress incontinence (eg, fascia or synthetic)*. The RUC reviewed the pre-service times and immediate post-service physician times. The RUC determined that the survey respondents over-estimated the pre- and immediate post-service times as they indicated significantly higher times compared to the current physician time associated with this service and physician times for similar services. The RUC recommends 40 minutes pre-evaluation, 10 minutes pre-positioning, 10 minutes scrub, dress, wait time and 20 minutes immediate post-service time.

The survey median RVU for 57287 was 13.00. However, since this service is predominantly performed in the hospital outpatient setting, the specialty society recommended starting with the survey median of 13.00 and delete one 99323 visit, reduce the discharge day to a half-day and remove the associated RVUs with these post-operative visit deletions, ( $13.00 - 1.39 - 0.64 = 10.97$ ). The RUC recommends a half day 99238, 1-99212 and 3-99213 post-operative visits.

Additionally, the RUC compared this service to code 53852 *Transurethral destruction of prostate tissue; by radiofrequency thermotherapy* (work RVU = 10.68, intra-service time = 58 minutes) as a reference to further support the recommendation of 10.97 for code 57287. **The RUC recommends a work RVU of 10.97 for code 57287.**

#### **Practice Expense**

These services are typically performed in the facility setting. The direct practice expense inputs, specifically for the assist physician time and the number of post-operative visits for codes 51102, 53445, 54410, 54530 and 57287 are recommended to be modified to reflect the current survey data. The practice expense inputs for the number of post-operative visits for codes 52341, 52342, 52343, 52344, 52345, 52346, 52400, 52500 and 52640 are recommended to be modified as revised above. The RUC recommends the practice expense for code 54405 be maintained.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
51010 (51102)	Aspiration of bladder; with insertion of suprapubic catheter	000	2.70
52341	Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	5.35
52342	Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	5.85
52343	Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	6.55
52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.05
52345	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.55
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	8.58
52400	Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds	090	8.66

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
52500	Transurethral resection of bladder neck (separate procedure)	090	7.99
52640	Transurethral resection; of postoperative bladder neck contracture	090	4.73
53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff	090	15.21
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir	090	14.39
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session	090	15.00
54530	Orchiectomy, radical, for tumor; inguinal approach	090	8.35
57287	Removal or revision of sling for stress incontinence (eg, fascia or synthetic)	090	10.97

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 52341      Tracking Number  
Global Period: 000

Specialty Society Recommended RVU: **7.94**  
RUC Recommended RVU: **5.35**

CPT Descriptor: Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58-year old man has chronic left flank pain. Studies demonstrate left hydronephrosis secondary to a lower ureteral stricture. The patient elects endoscopic rather than open surgical treatment.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 33%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 33%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work: The patient is in the dorsal lithotomy position. The cystoscope is introduced through the urethra into the bladder. The bladder is inspected with 30 degree and 70 degree lenses. The ureteral orifice is visualized. A guide wire is passed up the ureter. A high pressure balloon is passed over the guide wire to the strictured area and inflated. After an appropriate length of time, the balloon is deflated and removed. A Foley catheter is placed.

Description of Post-Service Work: The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D				
Specialty(s):	American Urological Association (AUA)				
CPT Code:	52341				
Sample Size:	1107	Resp N:	100	Response: 9.0 %	
Sample Type:	Random				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate	1.00	2.00	5.00	10.00	125.00
Survey RVW:	3.00	6.20	7.30	8.13	10.50
Pre-Service Evaluation Time:			45.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			15.0		
Intra-Service Time:	5.00	40.00	45.00	60.00	180.00
Immediate Post Service-Time:	<u>20.00</u>				
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	52341				
		<u>Specialty Recommended</u>			
Physician Work RVU:		7.94			
Pre-Service Evaluation Time:		45.0			
Pre-Service Positioning Time:		10.0			
Pre-Service Scrub, Dress, Wait Time:		15.0			
Intra-Service Time:		45.00			
Immediate Post Service-Time:	<u>20.00</u>				
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52354	000	7.33	Harvard Time

CPT Descriptor Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
31600	000	44,896	7.17		
<u>CPT Descriptor 1</u> Tracheostomy, planned (separate procedure)					
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 52341	<u>Key Reference CPT Code:</u> 52354	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	70.00	58.00	
Median Intra-Service Time	45.00	86.00	
Median Immediate Post-service Time	20.00	23.00	
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	
Prolonged Services Time	0.0	0.00	

Median Total Time	135.00	167.00
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	3.62
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.48
--	------	------

Urgency of medical decision making	3.24	3.33
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.95	4.00
--------------------------	------	------

Physical effort required	3.24	3.33
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.57	3.71
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Outcome depends on the skill and judgment of physician	3.71	3.76
--	------	------

Estimated risk of malpractice suit with poor outcome	3.33	3.38
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.90	2.90
----------------------------------	------	------

Intra-Service intensity/complexity	3.62	3.67
------------------------------------	------	------

Post-Service intensity/complexity	2.76	2.86
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**Additional Rationale**

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

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52341

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 2000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 1,893  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code 52341

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:52342      Tracking Number  
Global Period: 000

Specialty Society Recommended RVU: **8.64**  
RUC Recommended RVU: **5.85**

CPT Descriptor: Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58-year-old man with chronic left flank pain. Studies demonstrate left hydronephrosis secondary to an ureteropelvic junction obstruction. The patient elects endoscopic rather than open surgical treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 19%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 13%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work: The patient is in the dorsal lithotomy position. The cystoscope is introduced through the urethra into the bladder. The bladder is thoroughly inspected with both the 30 degree and 70 degree lenses. The ureteral orifice is visualized. A guide wire is passed up the ureter. A high pressure balloon is passed over the guidewire to the strictured area and inflated. After an appropriate length of time, the balloon is deflated and removed. A Foley catheter is placed.

Description of Post-Service Work: The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Thomas P. Cooper, M.D.; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D.				
Specialty(s):	American Urological Association (AUA)				
CPT Code:	52342				
Sample Size:	1107	Resp N:	41	Response: 3.7 %	
Sample Type:	Random				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate	1.00	2.00	5.00	10.00	25.00
Survey RVW:	5.00	7.32	8.00	8.50	9.51
Pre-Service Evaluation Time:			40.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	5.00	45.00	60.00	75.00	180.00
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	52342				
		<u>Specialty Recommended</u>			
Physician Work RVU:	8.64				
Pre-Service Evaluation Time:	40.0				
Pre-Service Positioning Time:	10.0				
Pre-Service Scrub, Dress, Wait Time:	10.0				
Intra-Service Time:	60.00				
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52355	000	8.81	CMS Time File

CPT Descriptor Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		
11012	000	7,603	6.87	RUC Time

CPT Descriptor 1 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 39.0 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 52342	<u>Key Reference CPT Code:</u> 52355	<u>Source of Time</u> CMS Time File
Median Pre-Service Time	60.00	0.00	
Median Intra-Service Time	60.00	0.00	
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	
Prolonged Services Time	0.0	0.00	

Median Total Time	140.00	0.00
Other time if appropriate		175.00

**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	3.94	4.06
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.31	4.31
--	------	------

Urgency of medical decision making	3.44	3.94
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.44	4.50
--------------------------	------	------

Physical effort required	3.81	3.88
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.25	4.38
---	------	------

Outcome depends on the skill and judgment of physician	4.44	4.44
--	------	------

Estimated risk of malpractice suit with poor outcome	4.06	4.25
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.63	3.75
----------------------------------	------	------

Intra-Service intensity/complexity	4.44	4.44
------------------------------------	------	------

Post-Service intensity/complexity	3.75	3.75
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**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.

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52342

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 400  
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 348  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:52343      Tracking Number  
Global Period: 000

Specialty Society Recommended RVU: **9.16**  
RUC Recommended RVU: **6.55**

CPT Descriptor: Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)

---

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 56-year-old man has intermittent, severe left flank pain. Studies demonstrate a dilated upper pole calyx with stenosis of the infundibulum. He elects endoscopic rather than open surgical treatment

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 29%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 21%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work: The patient is in the dorsal lithotomy position. The cystoscope is introduced through the urethra into the bladder. The bladder is thoroughly inspected with both the 30 degree and 70 degree lenses. The ureteral orifice is visualized. A guide wire is passed up the ureter. A high pressure balloon is passed over the guidewire to the strictured area and inflated. After an appropriate length of time, the balloon is deflated and removed. A Foley catheter is placed.

Description of Post-Service Work: The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008					
Presenter(s):	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D					
Specialty(s):	American Urological Association (AUA)					
CPT Code:	52343					
Sample Size:	1107	Resp N:	31	Response: 2.8 %		
Sample Type:	Random					
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl	High
Service Performance Rate		1.00	3.00	8.50	18.00	120.00
Survey RVW:		6.10	7.50	8.52	8.86	10.21
Pre-Service Evaluation Time:				45.0		
Pre-Service Positioning Time:				10.0		
Pre-Service Scrub, Dress, Wait Time:				10.0		
Intra-Service Time:		5.00	47.50	60.00	77.50	120.00
Immediate Post Service-Time:	<u>25.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	52343					
		<u>Specialty Recommended</u>				
Physician Work RVU:		9.16				
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				
Immediate Post Service-Time:	<u>25.00</u>					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.0	99239x 0.0			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52355	000	8.81	CMS Time File

CPT Descriptor Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		
58561	000	1,022	9.99	RUC Time
<u>CPT Descriptor 1</u> Hysteroscopy, surgical; with removal of leiomyomata				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 45.1 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u>	<u>Key Reference CPT Code:</u>	<u>Source of Time</u>
	52343	52355	CMS Time File

Median Pre-Service Time	65.00	0.00
-------------------------	-------	------

Median Intra-Service Time	60.00	0.00
---------------------------	-------	------

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
--------------------------	-----	------

Prolonged Services Time	0.0	0.00
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Median Total Time	150.00	0.00
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Other time if appropriate		175.00
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**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	3.93
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.29	4.00
--	------	------

Urgency of medical decision making	3.50	3.50
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.50	4.36
--------------------------	------	------

Physical effort required	3.86	3.86
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.14	4.14
---	------	------

Outcome depends on the skill and judgment of physician	4.36	4.36
--	------	------

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	3.57	3.43
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	3.71
------------------------------------	------	------

Post-Service intensity/complexity	3.43	3.43
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**Additional Rationale**

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

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52343

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 60

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 46 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for 52343

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 52344      Tracking Number  
Global Period: 000

Specialty Society Recommended RVU: **8.44**  
RUC Recommended RVU: **7.05**

CPT Descriptor: Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 58-year-old man with chronic left flank pain. Studies demonstrate left hydronephrosis with a lower ureteral stricture. The patient elects ureteroscopic rather than open surgical treatment.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 38%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 25%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work: The patient is in the dorsal lithotomy position. The cystoscope is introduced through the urethra into the bladder. The bladder is thoroughly inspected with both the 30 degreee and 70 degree lenses. The ureteral orifice is visualized. A guide wire is passed up the ureter through the cystoscope. The cystoscope is removed and the ureteroscope passed over the guidewire through the urethra into the bladder and then up the ureter. A high pressure balloon is passed over the guidewire to the strictured area and inflated. After an appropriate length of time, the balloon is deflated and removed. A Foley catheter is placed.

Description of Post-Service Work: The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Thomas P. Cooper, M.D.; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D.				
Specialty(s):	American Urological Association (AUA)				
CPT Code:	52344				
Sample Size:	1107	Resp N:	31	Response: 2.8 %	
Sample Type:	Random				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate	1.00	2.00	5.00	5.25	20.00
Survey RVW:	5.20	7.00	7.80	8.00	9.10
Pre-Service Evaluation Time:			40.0		
Pre-Service Positioning Time:			10.0		
Pre-Service Scrub, Dress, Wait Time:			10.0		
Intra-Service Time:	5.00	45.00	45.00	60.00	90.00
Immediate Post Service-Time:	<u>20.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40), 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	52344				
		<u>Specialty Recommended</u>			
Physician Work RVU:		8.44			
Pre-Service Evaluation Time:		40.0			
Pre-Service Positioning Time:		10.0			
Pre-Service Scrub, Dress, Wait Time:		10.0			
Intra-Service Time:		45.00			
Immediate Post Service-Time:	<u>20.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.0	99239x 0.0		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52354	000	7.33	Harvard Time

CPT Descriptor Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion

**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.

<u>Most Recent</u>			
<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>
11012	000	7,603	6.87
<u>CPT Descriptor 1</u> Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone			
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 25.8 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 52344	<u>Key Reference CPT Code:</u> 52354	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	60.00	58.00	
Median Intra-Service Time	45.00	86.00	
Median Immediate Post-service Time	20.00	23.00	
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	

Prolonged Services Time	0.0	0.00
Median Total Time	125.00	167.00
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	3.75
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.88
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Urgency of medical decision making	3.63	3.50
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.00	4.00
--------------------------	------	------

Physical effort required	3.63	3.63
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	4.13
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Outcome depends on the skill and judgment of physician	4.13	4.25
--	------	------

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	3.38	3.38
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Intra-Service intensity/complexity	3.75	3.88
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Post-Service intensity/complexity	3.00	3.00
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**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.*

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52344

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 2200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 2,084  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code 52344

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 52345      Tracking Number  
Global Period: 000

Specialty Society Recommended RVU: 8.56  
RUC Recommended RVU: 7.55

CPT Descriptor: Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 21-year-old woman has a history of intermittent, severe left flank pain, especially noted after drinking alcohol. Studies demonstrate a left ureteropelvic junction obstruction. The patient elects ureteroscopic treatment of the obstruction instead of an open pyeloplasty.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 30%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 10%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Appropriate pre-operative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work: The patient is placed in the dorsal lithotomy position. Preliminary cystoscopy is carried out. The bladder is thoroughly inspected with both the 30 degree and 70 degree lenses. The ureteral orifice is identified and a guide wire is introduced through the cystoscope into the ureteral orifice. The cystoscope is removed and a ureteroscope is passed over the guidewire through the urethra to the bladder and then into the ureter. The ureteroscope is gradually passed up the ureter, over the iliac vessels and into the upper ureter. The pinpoint opening of the UPJ is visualized. A second guide wire is placed. The electrocautery balloon is positioned and the strictured area is treated successfully. The area is carefully inspected, there is no bleeding. The instruments are removed.

Description of Post-Service Work: The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008					
Presenter(s):	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D					
Specialty(s):	American Urological Association (AUA)					
CPT Code:	52345					
Sample Size:	1107	Resp N:	26	Response: 2.3 %		
Sample Type:	Random					
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate		1.00	1.00	3.00	6.50	15.00
Survey RVW:		5.50	7.50	7.92	8.50	10.22
Pre-Service Evaluation Time:				45.0		
Pre-Service Positioning Time:				10.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		5.00	40.00	45.00	60.00	90.00
Immediate Post Service-Time:	<u>20.00</u>					
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit. 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	52345					
		<u>Specialty Recommended</u>				
Physician Work RVU:		8.56				
Pre-Service Evaluation Time:		45.0				
Pre-Service Positioning Time:		10.0				
Pre-Service Scrub, Dress, Wait Time:		15.0				
Intra-Service Time:		45.00				
Immediate Post Service-Time:	<u>20.00</u>					
Post Operative Visits	<u>Total Min**</u>	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.0	99239x 0.0			
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52354	000	7.33	Harvard Time

CPT Descriptor Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Medicare Utilization</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
			RUC Time		
11012	000	7,603	6.87		
<u>CPT Descriptor 1</u> Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone					
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Medicare Utilization</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
			RUC Time		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 38.4 %**

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 52345	<u>Key Reference CPT Code:</u> 52354	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	70.00	58.00	
Median Intra-Service Time	45.00	86.00	
Median Immediate Post-service Time	20.00	23.00	
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	

Prolonged Services Time	0.0	0.00
Median Total Time	135.00	167.00
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	3.70	3.80
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.80
--	------	------

Urgency of medical decision making	3.70	3.40
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.10	4.10
--------------------------	------	------

Physical effort required	3.60	3.80
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.10	4.10
--	------	------

Estimated risk of malpractice suit with poor outcome	3.50	3.60
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

CPT Code      Reference  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.20	3.20
----------------------------------	------	------

Intra-Service intensity/complexity	3.60	3.80
------------------------------------	------	------

Post-Service intensity/complexity	3.30	3.30
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**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.

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52345

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 481  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code 52345

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 52346      Tracking Number  
Global Period: 000

Specialty Society Recommended RVU: **8.69**  
RUC Recommended RVU: **8.58**

CPT Descriptor: Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)

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**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 56-year-old man has intermittent severe left flank pain. Studies demonstrate a dilated upper pole calyx with stenosis of the infundibulum. He elects ureteroscopic rather than open surgical treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 20%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 20%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before being given an anesthetic. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

Description of Intra-Service Work: The patient is in the dorsal lithotomy position. Preliminary cystoscopy is carried out and the bladder thoroughly inspected with the 30 degree and 70 degree lenses. The ureteral orifice is identified. A guidewire is placed into the ureteral orifice. The cystoscope is then removed and the ureteroscope advanced over the guidewire through the urethra, into the bladder and then into the ureter. The ureteroscope is then passed slowly up the ureter, up the iliac vessels and into the renal pelvis. The obstructing infundibulum is identified and a second guide wire is passed through the small opening and coiled into the dilated calyx. A laser fiber is introduced and the opening is carefully enlarged. Bleeding is minimal. The instruments are removed.

Description of Post-Service Work: The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Hospital by-laws require that a detailed discharge summary must be dictated.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D				
Specialty(s):	American Urological Association (AUA)				
CPT Code:	52346				
Sample Size:	1107	Resp N:	24	Response: 2.1 %	
Sample Type:	Random				
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		1.00	1.00	2.00	4.00
Survey RVW:		5.00	8.00	8.05	8.84
Pre-Service Evaluation Time:				40.0	
Pre-Service Positioning Time:				10.0	
Pre-Service Scrub, Dress, Wait Time:				10.0	
Intra-Service Time:		5.00	43.75	60.00	90.00
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.0</u>	99211x 0.0	12x 0.0	13x 0.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	52346	
		Specialty Recommended
Physician Work RVU:		8.69
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		10.0
Intra-Service Time:		60.00
Immediate Post Service-Time:	<u>20.00</u>	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0
Discharge Day Mgmt:	<u>0.0</u>	99238x 0.0
Office time/visit(s):	<u>0.0</u>	99211x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52355	000	8.81	CMS Time File

CPT Descriptor Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		
11012	000	7,603	6.87	RUC Time

CPT Descriptor 1 Debridement including removal of foreign material associated with open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 41.6 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>52346</u>	<u>Key Reference CPT Code:</u> <u>52355</u>	<u>Source of Time</u> <u>CMS Time File</u>
Median Pre-Service Time	60.00	0.00	
Median Intra-Service Time	60.00	0.00	
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	
Prolonged Services Time	0.0	0.00	

Median Total Time	140.00	0.00
Other time if appropriate		175.00

**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	3.70	3.70
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.90
--	------	------

Urgency of medical decision making	3.50	3.50
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.40	4.10
--------------------------	------	------

Physical effort required	3.90	3.60
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.00	4.10
---	------	------

Outcome depends on the skill and judgment of physician	4.20	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	3.90	3.90
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.80	3.70
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	3.80
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.44
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**Additional Rationale**

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

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52346

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 65

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 57 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code 52346

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code: 52400      Tracking Number  
 Global Period: 090

Specialty Society Recommended RVU: **12.58**  
 RUC Recommended RVU: **8.66**

CPT Descriptor: Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 2-month-old boy presents with a poor urinary stream, palpable bladder, and elevated serum creatinine. He has severe vesicoureteral reflux secondary to congenital urethral valves.

Percentage of Survey Respondents who found Vignette to be Typical: 48%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 17%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 15%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Pre-service work – Day before surgery

- Review medical records
- Review VCUG and renal sonogram
- Write pre-op orders (to be faxed to hospital)
- Obtain consent for procedure from parents

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 (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
- Calibrate the urethral meatus with urethral dilators
- Insert cystoscope 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, inspect valves and site for incision, inspect verumontanum
- 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,
- 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
- An external meatomy is performed if necessary
- The infant 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 obstructing valves are incised at the 5, 7 and 12 O'clock positions. The bladder is filled with irrigation fluid • The rectosheath is removed and compression of the bladder is performed to confirm a excellent urinary stream with minimal compression.
- If the stream is weak, the infant resectoscope is introduced again
- The obturator is removed, the bladder drained, and the working element is placed
- The power cord, camera and light source are re-attached
- The obstructing valves are re-incised at the 5, 7 and 12 o'clock positions
- Disconnect video equipment and light source
- Remove the resectoscope and sheath
- At the end of the procedure a lubricated catheter is inserted
- The catheter is taped to the penis and the catheter is connected to a bag for drainage

#### 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
- 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
- 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

Post-op Same day work after discharge from recovery

- Examine patient, check bladder and patient progress
- Conduct post-op pain assessment
- 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
- Remove catheter
- 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
- 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
- Arrange appropriate postoperative follow up

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D				
Specialty(s):	American Urological Association (AUA)				
CPT Code:	52400				
Sample Size:	952	Resp N:	60	<b>Response: 6.3 %</b>	
Sample Type:	Random				
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>
Service Performance Rate		1.00	3.00	<b>4.00</b>	5.00
Survey RVW:		8.54	13.75	<b>16.00</b>	17.75
Pre-Service Evaluation Time:				<b>72.5</b>	
Pre-Service Positioning Time:				<b>10.0</b>	
Pre-Service Scrub, Dress, Wait Time:				<b>15.0</b>	
Intra-Service Time:		10.00	30.00	<b>40.00</b>	45.00
Immediate Post Service-Time:	<b><u>25.00</u></b>				
Post Operative Visits	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<b><u>0.0</u></b>	99291x <b>0.0</b>	99292x <b>0.0</b>		
Other Hospital time/visit(s):	<b><u>80.0</u></b>	99231x <b>0.0</b>	99232x <b>2.0</b>	99233x <b>0.0</b>	
Discharge Day Mgmt:	<b><u>38.0</u></b>	99238x <b>1.00</b>	99239x <b>0.00</b>		
Office time/visit(s):	<b><u>109.0</u></b>	99211x <b>0.0</b>	12x <b>0.0</b>	13x <b>3.0</b>	14x <b>1.0</b>
Prolonged Services:	<b><u>0.0</u></b>	99354x <b>0.0</b>	55x <b>0.0</b>	56x <b>0.0</b>	57x <b>0.0</b>

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	52400	
		<u>Specialty Recommended</u>
Physician Work RVU:		<b>12.58</b>
Pre-Service Evaluation Time:		<b>72.5</b>
Pre-Service Positioning Time:		<b>10.0</b>
Pre-Service Scrub, Dress, Wait Time:		<b>15.0</b>
Intra-Service Time:		<b>40.00</b>
Immediate Post Service-Time:	<b><u>25.00</u></b>	
Post Operative Visits	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>
Critical Care time/visit(s):	<b><u>0.0</u></b>	99291x <b>0.0</b>
Other Hospital time/visit(s):	<b><u>0.0</u></b>	99231x <b>0.0</b>
Discharge Day Mgmt:	<b><u>19.0</u></b>	99238x <b>0.5</b>
Office time/visit(s):	<b><u>16.0</u></b>	99211x <b>0.0</b>
Prolonged Services:	<b><u>0.0</u></b>	99354x <b>0.0</b>

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52601	090	15.13	RUC Time

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)

**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.

<u>MPC CPT Code 1</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
	<u>Global</u>	<u>Medicare Utilization</u>		
36830	090	35,108	12.00	RUC Time

CPT Descriptor 1 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)

<u>MPC CPT Code 2</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
	<u>Global</u>	<u>Medicare Utilization</u>		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 41 % of respondents: 68.3 %

**TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 52400	<u>Key Reference CPT Code:</u> 52601	<u>Source of Time</u> RUC Time
Median Pre-Service Time	97.50	60.00	
Median Intra-Service Time	40.00	75.00	
Median Immediate Post-service Time	25.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	80.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	16.0	62.00	

Prolonged Services Time	0.0	0.00
Median Total Time	197.50	355.00
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	3.84	3.32
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.86	3.22
--	------	------

Urgency of medical decision making	4.32	2.95
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.27	4.17
--------------------------	------	------

Physical effort required	3.68	3.38
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.27	4.35
---	------	------

Outcome depends on the skill and judgment of physician	3.46	4.43
--	------	------

Estimated risk of malpractice suit with poor outcome	3.70	3.97
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**  
**Reference**  
**Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.03	3.27
----------------------------------	------	------

Intra-Service intensity/complexity	3.43	3.41
------------------------------------	------	------

Post-Service intensity/complexity	3.89	3.19
-----------------------------------	------	------

**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.*

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52400

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 1500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 1.115

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code 52400

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty              Frequency 0              Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 52500      Tracking Number  
Global Period: 090

Specialty Society Recommended RVU: **10.47**  
RUC Recommended RVU: **7.99**

CPT Descriptor: Transurethral resection of bladder neck (separate procedure)

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 67-year-old man has an AUA symptom index of 29/35. Prior medical treatment with both finasteride and alpha blockers was unsuccessful in improving his urinary symptoms. Peak urinary flow rate is 3 ml/sec, cystometrogram is normal. Cystoscopy reveals a small prostate with a tight, hypertrophied, bladder neck.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 40%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 40%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: (1) obtaining and reviewing hospital admission laboratory studies and urologic x-rays before the procedure; (2) communicating with other health care professionals (e.g., family physician, anesthesiologist); (3) Communicating with the patient to explain operative risks and benefits and to obtain informed consent; (4) dressing for surgery, waiting for anesthesia (e.g., placing central arterial and venous lines, administering general, spinal and/or epidural anesthesia), positioning, prepping and draping the patient, and scrubbing; (5) preparing and checking needed equipment for surgery and any other non "skin-to-skin" work in the operating room.

Description of Intra-Service Work: Intra-service includes: connecting water; electrosurgical unit; video equipment; urethra is dilated to 30F; 27F resectoscope is introduced; prostatic urethra bladder neck and bladder are inspected; the bladder neck is circumferentially resected; all bleeders are coagulated; bladder neck tissue fragments are removed from the bladder using the Ellik Evacuator and a catheter is placed.

Description of Post-Service Work: (1) all post-operative care on the day of the procedure, including patient transfer to the recovery room and stabilization, post-operative orders, communicating with the family and referring physician (including written and telephone reports), and other non "skin-to-skin" work in the operating room; (2) post-operative discharge day management; (3) post-operative follow-up is arranged; (4) all post-discharge office visits for this procedure for 90 days after the day of the operation are considered part of the post-operative work for this procedure (including evaluation of periodic laboratory reports and medication adjustment)

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D				
Specialty(s):	American Urological Association (AUA)				
CPT Code:	52500				
Sample Size:	646	Resp N:	24	Response: 3.7 %	
Sample Type:	Random				
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		2.00	5.00	<b>7.50</b>	10.50
Survey RVW:		9.00	11.65	<b>12.50</b>	14.00
Pre-Service Evaluation Time:				<b>45.0</b>	
Pre-Service Positioning Time:				<b>10.0</b>	
Pre-Service Scrub, Dress, Wait Time:				<b>15.0</b>	
Intra-Service Time:		30.00	30.00	<b>45.00</b>	48.75
Immediate Post Service-Time:	<b>27.50</b>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<b>0.0</b>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<b>40.0</b>	99231x 0.0	99232x 1.0	99233x 0.0	
Discharge Day Mgmt:	<b>38.0</b>	99238x 1.00	99239x 0.00		
Office time/visit(s):	<b>62.0</b>	99211x 0.0	12x 1.0	13x 2.0	14x 0.0
Prolonged Services:	<b>0.0</b>	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	52500				
		<u>Specialty Recommended</u>			
Physician Work RVU:		<b>10.47</b>			
Pre-Service Evaluation Time:		<b>45.0</b>			
Pre-Service Positioning Time:		<b>10.0</b>			
Pre-Service Scrub, Dress, Wait Time:		<b>15.0</b>			
Intra-Service Time:		<b>45.00</b>			
Immediate Post Service-Time:	<b>27.50</b>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<b>0.0</b>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<b>19.0</b>	99238x 0.5	99239x 0.0		
Office time/visit(s):	<b>69.0</b>	99211x 0.0	12x 0.0	13x 3.0	14x 0.0
Prolonged Services:	<b>0.0</b>	55x 0.0	56x 0.0	57x 0.0	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52601	090	15.13	RUC Time

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

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
58660	090	<u>CPT Descriptor 1</u> Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)		11.54	RUC Time
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 62.5 %**

**TIME ESTIMATES (Median)**

<u>CPT Code:</u> 52500	<u>Key Reference CPT Code:</u> 52601	<u>Source of Time</u> RUC Time
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Median Pre-Service Time	70.00	60.00
Median Intra-Service Time	45.00	75.00
Median Immediate Post-service Time	27.50	40.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	80.00
Median Discharge Day Management Time	19.0	38.00
Median Office Visit Time	69.0	62.00
Prolonged Services Time	0.0	0.00

Median Total Time	230.50	355.00
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	3.40
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.60
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Urgency of medical decision making	3.13	3.20
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.53	3.73
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Physical effort required	3.47	3.60
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.47	3.80
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Outcome depends on the skill and judgment of physician	3.67	3.73
--	------	------

Estimated risk of malpractice suit with poor outcome	3.40	3.53
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**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference Service 1**

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.53	3.60
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Intra-Service intensity/complexity	3.53	3.80
------------------------------------	------	------

Post-Service intensity/complexity	3.33	3.47
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**Additional Rationale**

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

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 52500

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
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Estimate the number of times this service might be provided nationally in a one-year period? 6800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,512  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code 52500

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? Yes

If no, please select another crosswalk and provide a brief rationale.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code: 53445      Tracking Number  
 Global Period: 090

Specialty Society Recommended RVU: **15.21**  
 RUC Recommended RVU: **15.21**

CPT Descriptor: Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: Eighteen months following a radical retropubic prostatectomy, a 62-year-old man has an undetectable PSA but intractable stress urinary incontinence requiring 7 pads a day. After appropriate counseling regarding all therapeutic options, the patient elects to have an artificial urinary sphincter inserted.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 11%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 11%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? 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 faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

Pre-service work- Day of surgery:

- Change into scrub cloths
- 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 operating table
- Verify that all necessary instruments and prosthetic components are available

Description of Intra-Service Work:

- A Foley catheter is placed
- With patient in lithotomy position, a perineal incision is made and the urethra is delicately mobilized
- A sizer is used to measure the circumference of the urethra
- A urethral cuff is very carefully placed around the urethra
- The cuff tubing is placed through the inguinal ring  
 The perineum is closed in a layered fashion with subcuticular skin closure
- Patient is repositioned supine and re-prepped and draped
- Infra pubic incision is made
- Electrocautery dissection is done
- Rectus muscles are opened and reservoir space created and dilated
- Scrotal pouch is dissected and the pump/activation-deactivation system is placed

- The wound and prosthetic components are irrigated throughout the procedure with antibiotic solution spray
- The reservoir is placed beneath rectus muscles, space is closed
- The pump/activation-deactivation system is placed in the scrotum
- System is filled with fluid and connections are made
- System is tested
- Wound is irrigated
- Closure of abdomen and perineum, is done in usual fashion

**Description of Post-Service Work:**

Post-op Same day work through discharge from recovery

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- 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
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

Post-op Same day work after discharge from recovery

- Examine patient, check wound and patient progress
- 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 (if applicable)

- Examine and talk to patient
- Check wounds and dressings
- Discuss patient progress with patient and family
- Review all patient hospital medical record notes
- Discuss post operative care of wound and prosthesis at home
- Answer nursing and other staff questions
- Answer patient and family questions
- Write orders in medical record
- Write progress notes

**Discharge day work:**

- Examine and talk with patient and family
- Check wounds 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 prosthesis with patient and family
- Dictate detailed hospital discharge summary
- Arrange post-operative follow-up

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	02/2008					
<b>Presenter(s):</b>	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D.					
<b>Specialty(s):</b>	American Urological Association (AUA)					
<b>CPT Code:</b>	53445					
<b>Sample Size:</b>	1279	<b>Resp N:</b>	26	<b>Response:</b> 2.0 %		
<b>Sample Type:</b>	Random					
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>	
<b>Service Performance Rate</b>	1.00	3.00	5.50	14.00	40.00	
<b>Survey RVW:</b>	10.26	13.00	14.00	14.14	23.50	
<b>Pre-Service Evaluation Time:</b>			50.0			
<b>Pre-Service Positioning Time:</b>			15.0			
<b>Pre-Service Scrub, Dress, Wait Time:</b>			20.0			
<b>Intra-Service Time:</b>	45.00	78.75	90.00	120.00	180.00	
<b>Immediate Post Service-Time:</b>	<u>25.00</u>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>95.0</u>	99231x 0.0	99232x 1.0	99233x 1.0		
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.00	99239x 0.00			
Office time/visit(s):	<u>85.0</u>	99211x 0.0	12x 1.0	13x 3.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

<b>CPT Code:</b>	53445					
	<u>Specialty Recommended</u>					
<b>Physician Work RVU:</b>	15.21					
<b>Pre-Service Evaluation Time:</b>	50.0					
<b>Pre-Service Positioning Time:</b>	15.0					
<b>Pre-Service Scrub, Dress, Wait Time:</b>	20.0					
<b>Intra-Service Time:</b>	90.00					
<b>Immediate Post Service-Time:</b>	<u>25.00</u>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>95.0</u>	99231x 0.0	99232x 1.0	99233x 1.0		
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.0	99239x 0.0			
Office time/visit(s):	<u>85.0</u>	99211x 0.0	12x 1.0	13x 3.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
53447	090	14.15	RUC Time

CPT Descriptor Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		
58720	090	7,760	12.08	RUC Time
<u>CPT Descriptor 1</u> Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 34.6 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 53445	<u>Key Reference CPT Code:</u> 53447	<u>Source of Time</u> RUC Time
Median Pre-Service Time	85.00	50.00	
Median Intra-Service Time	90.00	140.00	
Median Immediate Post-service Time	25.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	95.0	20.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	62.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	418.00	340.00
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	4.22	3.44
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.78	3.67
--	------	------

Urgency of medical decision making	3.22	3.33
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.33	4.33
--------------------------	------	------

Physical effort required	3.67	3.89
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.11	4.22
---	------	------

Outcome depends on the skill and judgment of physician	4.33	4.33
--	------	------

Estimated risk of malpractice suit with poor outcome	3.78	3.78
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	4.11	4.22
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	4.22
------------------------------------	------	------

Post-Service intensity/complexity	3.78	4.00
-----------------------------------	------	------

**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.*

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 53445

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty	How often?
-----------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 2500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,910  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for code 53445

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Current code 53445

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:54410      Tracking Number  
 Global Period: 090

Specialty Society Recommended RVU: **15.84**  
 RUC Recommended RVU: **15.00**

CPT Descriptor: Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 77-year-old man had a multi-component, inflatable penile prosthesis placed 11 years ago. When having vigorous intercourse 2 days ago, he heard a "pop" and suddenly lost his erection. On exam the prosthesis will not inflate when compressing the scrotal pump. An x-ray confirms loss of fluid from the system. The patient is anxious to correct the problem as soon as possible. Removal of all old components and replacement with all new components of a multi-component, inflatable penile prosthesis is planned.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 25%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 25%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? 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 faxed to hospital)
- Check to be sure necessary prosthesis components are at hospital

**Pre-service work- Day of surgery:**

- Change into scrub cloths
- 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 operating table
- Verify that all necessary instruments and prosthetic components are available

**Description of Intra-Service Work:**

- A Foley catheter is placed
- A transverse infrapubic incision is made
- Dissection is done entirely with the electrocautery so as not to cut the prosthesis and tubing
- Fluid from the prosthesis is noted tracking along the tubing
- The tubing is traced to the cylinders in the corpora cavernosa
- Longitudinal corporotomies are made
- Both cylinders are delivered into the wound
- The right cylinder is noted to have a crack at the level of the tubing exit

- A leak in the system is identified at the tubing exit from the cylinder
- Tubing is divided from both cylinders
- New measurements of the corporal length are made
- Appropriate new penile prosthesis cylinders are selected and opened
- New connections to the old tubing are made and the system is carefully refilled with fluid to the exact amount necessary. The prostheses are pumped and deflated to make sure they work properly.
- The prostheses are then replaced in the corpora
- Rear Tip Extenders are added as necessary
- The wound is irrigated throughout the procedure with antibiotic spray
- The corporotomies are closed.
- The wound is irrigated and closed in usual fashion

**Description of Post-Service Work:****Post-op Same day work through discharge from recovery**

- Apply dressings
- Assist in transfer of patient from operating table to post-op stretcher
- Accompany anesthesiologist with patient to recovery area
- Assist in transfer of patient to recovery area bed
- Write post-op orders
- 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
- Call referring physician regarding outcome of procedure and any unusual aspects of post operative care (cardiac disease, diabetic management)
- Dictate detailed operative narrative

**Post-op Same day work after discharge from recovery**

- Examine patient, check wound and patient progress
- 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
- Arrange appropriate postoperative follow up

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D.				
Specialty(s):	American Urological Association (AUA)				
CPT Code:	54410				
Sample Size:	831	Resp N:	17	Response: 2.0 %	
Sample Type:	Random				
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		1.00	2.00	3.00	11.25
Survey RVW:		10.85	15.00	16.95	18.05
Pre-Service Evaluation Time:				55.0	
Pre-Service Positioning Time:				10.0	
Pre-Service Scrub, Dress, Wait Time:				15.0	
Intra-Service Time:		60.00	90.00	120.00	121.00
Immediate Post Service-Time:	30.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	0.0	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	95.0	99231x 0.0	99232x 1.0	99233x 1.0	
Discharge Day Mgmt:	38.0	99238x 1.00	99239x 0.00		
Office time/visit(s):	69.0	99211x 0.0	12x 0.0	13x 3.0	14x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	54410	
		<u>Specialty Recommended</u>
Physician Work RVU:		15.84
Pre-Service Evaluation Time:		40.0
Pre-Service Positioning Time:		10.0
Pre-Service Scrub, Dress, Wait Time:		15.0
Intra-Service Time:		120.00
Immediate Post Service-Time:	30.00	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.0	99291x 0.0
Other Hospital time/visit(s):	0.0	99231x 0.0
Discharge Day Mgmt:	38.0	99238x 1.0
Office time/visit(s):	85.0	99211x 0.0
Prolonged Services:	0.0	99354x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
54411	090	18.14	RUC Time

CPT Descriptor Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		
58720	090	7,760	12.08	RUC Time
<u>CPT Descriptor 1</u> Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 47.0 %

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>54410</u>	<u>Key Reference CPT Code:</u> <u>54411</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	65.00	50.00	
Median Intra-Service Time	120.00	180.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	180.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	85.0	102.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	338.00	580.00
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	3.88	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.75	3.88
--	------	------

Urgency of medical decision making	3.75	4.13
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.88	4.88
--------------------------	------	------

Physical effort required	4.13	4.25
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.63	4.75
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Outcome depends on the skill and judgment of physician	4.75	4.75
--	------	------

Estimated risk of malpractice suit with poor outcome	4.75	4.75
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	4.50	4.38
----------------------------------	------	------

Intra-Service intensity/complexity	4.63	4.63
------------------------------------	------	------

Post-Service intensity/complexity	4.25	4.38
-----------------------------------	------	------

**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.*

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 54410

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Estimate the number of times this service might be provided nationally in a one-year period? 1500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty Frequency 0 Percentage 0.00 %

Specialty                      Frequency 0                      Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,324  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for 54410

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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**Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Current code 54410

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:54530      Tracking Number  
Global Period: 090

Specialty Society Recommended RVU: **8.35**  
RUC Recommended RVU: **8.35**

CPT Descriptor: Orchietomy, radical, for tumor; inguinal approach

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 22-year-old male college student notices a left sided testicular mass. Ultrasound confirms the suspicious nature of the lesion. Serum tumor markers are drawn and the patient undergoes a left radical orchietomy.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 18%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 14%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

Appropriate preoperative studies are obtained and reviewed. The patient is seen by the operating surgeon before given being given an anesthetic. The surgical site is identified and marked. Procedure specific equipment is checked. The patient is taken to the operating room and given either general or spinal anesthesia, appropriately positioned for the procedure, prepped and draped.

**Description of Intra-Service Work:**

Local anesthesia with 0.25% Marcaine is instilled along the intended incision line. A right groin incision is made, the external oblique fascia is opened, the ilioinguinal nerve is preserved, the cord is mobilized and a Penrose drain tourniquet is placed around the cord. The testicle is then delivered out of the scrotum and into the wound, still attached to the cord. Towels are used to isolate the testis. The cord is clamped distally and proximally, is carefully divided at the internal ring, suture ligature and free tie applied to the cord stump. The scrotum is inverted and carefully inspected. Adequate hemostasis is achieved in the scrotum and inguinal wound. The fascia and subcutaneous layers are closed separately. A sterile dressing is applied.

**Description of Post-Service Work:**

The surgeon waits in the operating room and assists the anesthesiologist in transferring the patient to a recovery room stretcher. The patient is transferred to the recovery room. Post-operative orders are written. Prescriptions are written. A detailed operative report is dictated. The surgeon talks with the patient's family about the procedure, diagnosis, and postoperative care. The patient is seen by the surgeon later that day and if feeling well is dismissed home. Follow up appointment is arranged. Post operative care for the global period is included. Hospital by-laws require that a detailed discharge summary must be dictated.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	02/2008				
Presenter(s):	Thomas P. Cooper, M.D; Jeffrey A. Dann, M.D.; James G. Giblin, M.D.; Richard N. Gilbert, M.D				
Specialty(s):	American Urological Association (AUA)				
CPT Code:	54530				
Sample Size:	1117	Resp N:	74	Response: 6.6 %	
Sample Type:	Random				
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		1.00	2.00	3.00	5.00
Survey RVW:		6.90	9.21	10.38	12.55
Pre-Service Evaluation Time:				57.5	
Pre-Service Positioning Time:				10.0	
Pre-Service Scrub, Dress, Wait Time:				15.0	
Intra-Service Time:		15.00	45.00	60.00	60.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>40.0</u>	99231x 0.0	99232x 1.0	99233x 0.0	
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.00	99239x 0.00		
Office time/visit(s):	<u>86.0</u>	99211x 0.0	12x 0.0	13x 2.0	14x 1.0
Prolonged Services:	<u>0.0</u>	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	54530	
		<u>Specialty Recommended</u>
Physician Work RVU:	8.35	
Pre-Service Evaluation Time:	57.5	
Pre-Service Positioning Time:	10.0	
Pre-Service Scrub, Dress, Wait Time:	15.0	
Intra-Service Time:	60.00	
Immediate Post Service-Time:	<u>30.00</u>	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.5
Office time/visit(s):	<u>55.0</u>	99211x 0.0
Prolonged Services:	<u>0.0</u>	12x 2.0
		13x 1.0
		14x 0.0
		15x 0.0
		99354x 0.0
		55x 0.0
		56x 0.0
		57x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
54535	090	13.06	Harvard Time

CPT Descriptor Orchietomy, radical, for tumor; with abdominal exploration

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		
14060	090	92,953	9.07	RUC Time

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 37.8 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 54530	<u>Key Reference CPT Code:</u> 54535	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	82.50	57.00	

Median Intra-Service Time	60.00	83.00
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Median Immediate Post-service Time	30.00	23.00
------------------------------------	-------	-------

Median Critical Care Time	0.0	0.00
---------------------------	-----	------

Median Other Hospital Visit Time	0.0	40.00
----------------------------------	-----	-------

Median Discharge Day Management Time	19.0	38.00
--------------------------------------	------	-------

Median Office Visit Time	55.0	57.50
--------------------------	------	-------

Prolonged Services Time	0.0	0.00
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Median Total Time	246.50	298.50
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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	3.89	3.93
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.93
--	------	------

Urgency of medical decision making	4.25	4.29
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.46	3.57
--------------------------	------	------

Physical effort required	3.25	3.46
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.11	3.25
---	------	------

Outcome depends on the skill and judgment of physician	3.61	3.79
--	------	------

Estimated risk of malpractice suit with poor outcome	3.71	3.71
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.64	3.57
----------------------------------	------	------

Intra-Service intensity/complexity	3.39	3.61
------------------------------------	------	------

Post-Service intensity/complexity	3.50	3.50
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**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.

**SEE NEXT PAGE**

**2008 RVW Value for 54530= 9.31****Survey Median RVW = 10.38**

Since the service is predominantly performed in the hospital outpatient department the society agreed to the following revisions to the survey data:

- Deletions
  - Hospital visit (99232)
- Reduction
  - Discharge day, 50% reduction (99238)

These changes resulted in a decrease of the survey median RVW of 10.38 to 8.35.

		<b>Code</b>
	<b>Post-Op Visits</b>	<b>54530</b>
Median RVW		10.38
<b>Deletions/Reductions</b>	99232	1.39
	99238 (50%)	0.64
Recommended RVW		<b>8.35</b>

**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.

**FREQUENCY INFORMATION**

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 54530

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Urology

How often? Commonly

Specialty                    How often?

Specialty                    How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. expert panel estimate

Specialty                    Frequency 0                    Percentage 0.00 %

Specialty                    Frequency 0                    Percentage 0.00 %

Specialty                    Frequency 0                    Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,692

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2005 Medicare utilization data for 54530

Specialty                    Frequency 0                    Percentage 0.00 %

Specialty                    Frequency 0                    Percentage 0.00 %

Specialty                    Frequency 0                    Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. Current code 54530

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
February 2008 – Initial RUC Review

**Epidural Lysis**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT code 62263 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days,* the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 6.54. The enclosed letter from the specialty examines the flaw in the CMS methodology, explaining that using a building block from the ground up (or a zero-based building block methodology) results in a different work RVU. The original RUC recommendation that 62263 be valued higher than the base code 62264, is still appropriate and should factor in the work of the follow up office visits.

**The RUC recommends a work RVU of 6.54 for CPT code 62263.**

**February 2008 Initial RUC Review**

CPT code 62263 was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty societies presented data from 19 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 62264 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day* (Work RVU=4.42). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 194 minutes and 109 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the ASC or outpatient setting as the 2-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. The RUC determined that after an analysis of the survey intensity measures as compared with the reference code and of the calculated IWP/PUT of 62263 using the specialties recommended values and times (Current IWP/PUT=0.046, New IWP/PUT=0.0451), the current work RVU for this service is correct. Therefore, given the comparison to the reference code and the survey data, the RUC determined that the current work RVU for this service was appropriate.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
62263		Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	010	6.54 (No Change)

August 12, 2010

Barbara Levy, MD  
AMA/Specialty Society RVS Update Committee  
515 N. State Street  
Chicago, IL 60654

Re: Codes with site of service anomalies  
Codes 62263 – Tab 66  
Codes 62350, 62355, 62360, 62361, 62362, 62365 – Tab 67  
Codes 63650, 63685 – Tab 68

Dear Dr. Levy:

We are writing to respond to a request from the RUC to provide supplemental support for several RUC recommendations recently reviewed for site of service anomalies. The above-listed codes underwent review in February and April 2008. CMS has requested that the RUC review these services again and in the proposed rule for the 2011 Physician Fee Schedule, CMS notes that it has *“encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies.”*

We have applied a “zero-based building block” to the services referenced above. In this approach we started with a value of zero and built upwards. This is in contrast to the “reverse building block” CMS attempted in which they began with a starting value and pulled work out. That approach was clearly flawed as it resulted in a negative work RVU for several of the services to which it was applied.

In our zero-based approach, we used the accepted standards for pre- and post-service work intensities along with the times that were approved by the RUC in 2008. For intra-service complexity, we used the intensity of the reference service with the time the RUC approved for the code under review. When survey respondents were closely divided on their selected reference service, we provide an additional comparison in our attached spreadsheets. We also include a comparison with a code from the MPC list to further validate our values.

We request that the RUC consider the following elements as it reviews our response:

1. If CMS believes that the best way to ensure that the resources required to provide these services are appropriately valued is via a building block (as appears to be the case given the discussion in the Proposed Rule for the 2011 Medicare Physician Fee Schedule in the July 13, 2010 Federal Register), then CMS must be mindful of the vulnerabilities associated with relying solely on a building block. All components must be accurate and validated. In the reverse building block the starting values were certainly an issue.
2. A building block approach cannot capture the complexities, intricacies and subtleties involved in providing medical care. These would include those elements specified in the RUC survey:
  - a. Mental effort and judgment
  - b. Technical skill
  - c. Physical effort
  - d. Psychological stress

Since a building block cannot account for these factors, the zero-based building block arrives as the same value for several of the services to which we applied it even though there are distinctions between the services. These factors can be acknowledged when the services are reviewed by medically and scientifically trained physicians and other qualified providers.

3. The zero-based approach does serve overall to validate the RUC recommendations for these services. This is illustrated in the attached spreadsheet. However, there will be inconsistencies with any methodology and there are two instances where there is some variation between the RUC recommended value and the value derived from the building block:
  - a. Code 62263 - *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days.* As noted in the February 2008 Summary of Recommendation form, the recommended value for this code was already validated with use of two building block approaches. In the first one, the values of the post-procedures visits were added to the value for code 62264 - *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day .*

Code	RVU
62264	4.42
99213	0.92
99213	0.92
99212	.045
<b>TOTAL</b>	<b>6.71</b>

The SOR included additional support by adding two halves of code 62282 - *Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)* to the once day code:

Code	RVU
62264	4.42
62282 x .05	1.165
62282 x .05	1.165
<b>TOTAL</b>	<b>6.75</b>

- b. Code 63650 - *Percutaneous implantation of neurostimulator electrode array, epidural.* There was some difficulty in identifying codes that could serve as reference services for these surveys. Subsequent to the RUC reviews of these codes in February and April 2008, new codes have been established and valued that could serve as more appropriate intra-service proxies than the reference services that were then available. This is particularly germane for code 63650. A better proxy would be code 63663 - *Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including*

*fluoroscopy, when performed - which was reviewed by the RUC in April 2009.* Using this as the intra-service proxy would yield a RVUw of 6.19

	Intensity	Time	RVU
Pre Service			
Evaluation	.0224	33 min	0.7392
Positioning	.0224	10 min	0.224
Scrub/Dress/Wait	.0081	5 min	0.0405
Intra-Service (63663 as proxy)	.0521	60 min	3.126
Post-Service			
Immediate post-service	.0224	20 min	0.448
Visits within global period		# of visits	
99238	1.28	.05	0.64
99213	0.97	1.00	0.97
<b>TOTAL</b>			<b>6.187</b>

We believe that this approach does validate the RUC recommended values for these services and we strongly urge the RUC to convey that same conclusion to CMS. We further encourage CMS to accept these recommendations and maintain the current values assigned to these codes.

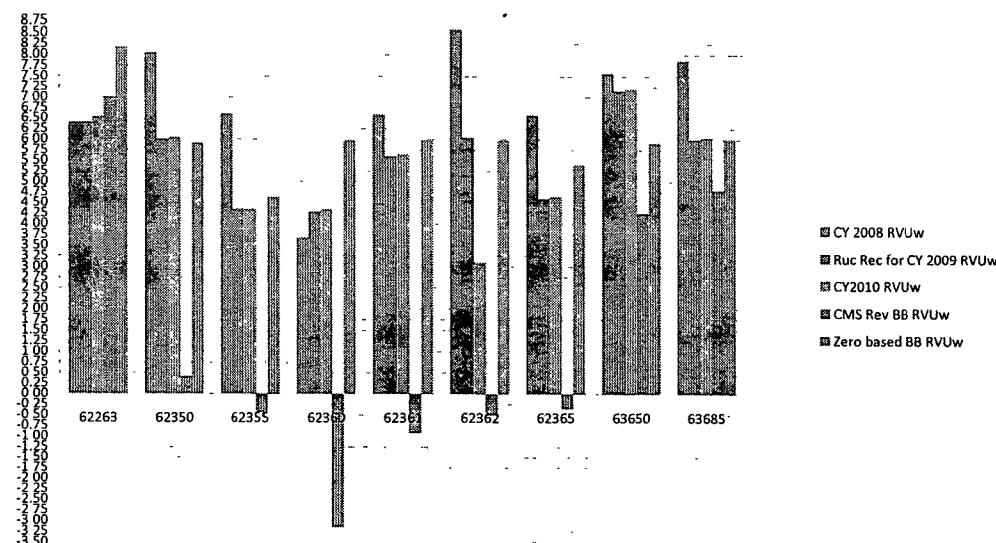
Sincerely,  
American Society of Anesthesiologists  
American Academy of Physical Medicine and Rehabilitation  
North American Spine Society  
American Academy of Pain Medicine  
International Spine Intervention Society  
American Association of Neurological Surgeons  
Congress of Neurological Surgeons

Encl

CY 2008 RVL Ruc Rec for CY 2009 CY2010 RV CMS Rev BB RVUw Zero based BB RVUw

	6.41	6.41	6.54	6.99	8.17
62263	6.41	6.00	6.05	0.41	5.92
62350	8.04	4.35	4.35	-0.43	4.63
62355	6.60	4.28	4.35	-3.14	5.98
62360	3.68	5.60	5.65	-0.92	5.98
62361	6.59	5.60	5.65	-0.92	5.98
62362	8.58	6.05	3.10	-0.51	5.98
62365	6.57	4.60	4.65	-0.35	5.41
63650	7.57	7.15	7.20	4.25	5.92
63685	7.87	6.00	6.05	4.80	5.98

zero based BB with reference service as intraservice proxy

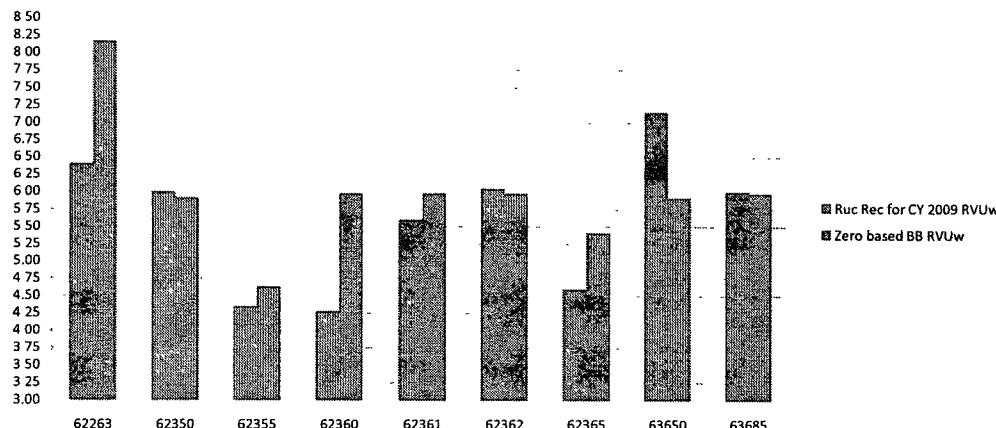


- CY 2008 RVUw
- Ruc Rec for CY 2009 RVUw
- CY2010 RVUw
- CMS Rev BB RVUw
- Zero based BB RVUw

Ruc Rec for CY Zero based BB RVUw

	6.41	8.17
62263	6.00	5.92
62350	4.35	4.63
62355	4.28	5.98
62360	5.60	5.98
62361	6.05	5.98
62362	4.60	5.41
62365	7.15	5.92
63650	6.00	5.98

zero based BB with reference service as intraservice proxy

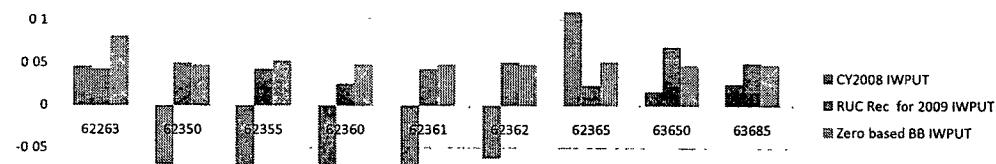


- Ruc Rec for CY 2009 RVUw
- Zero based BB RVUw

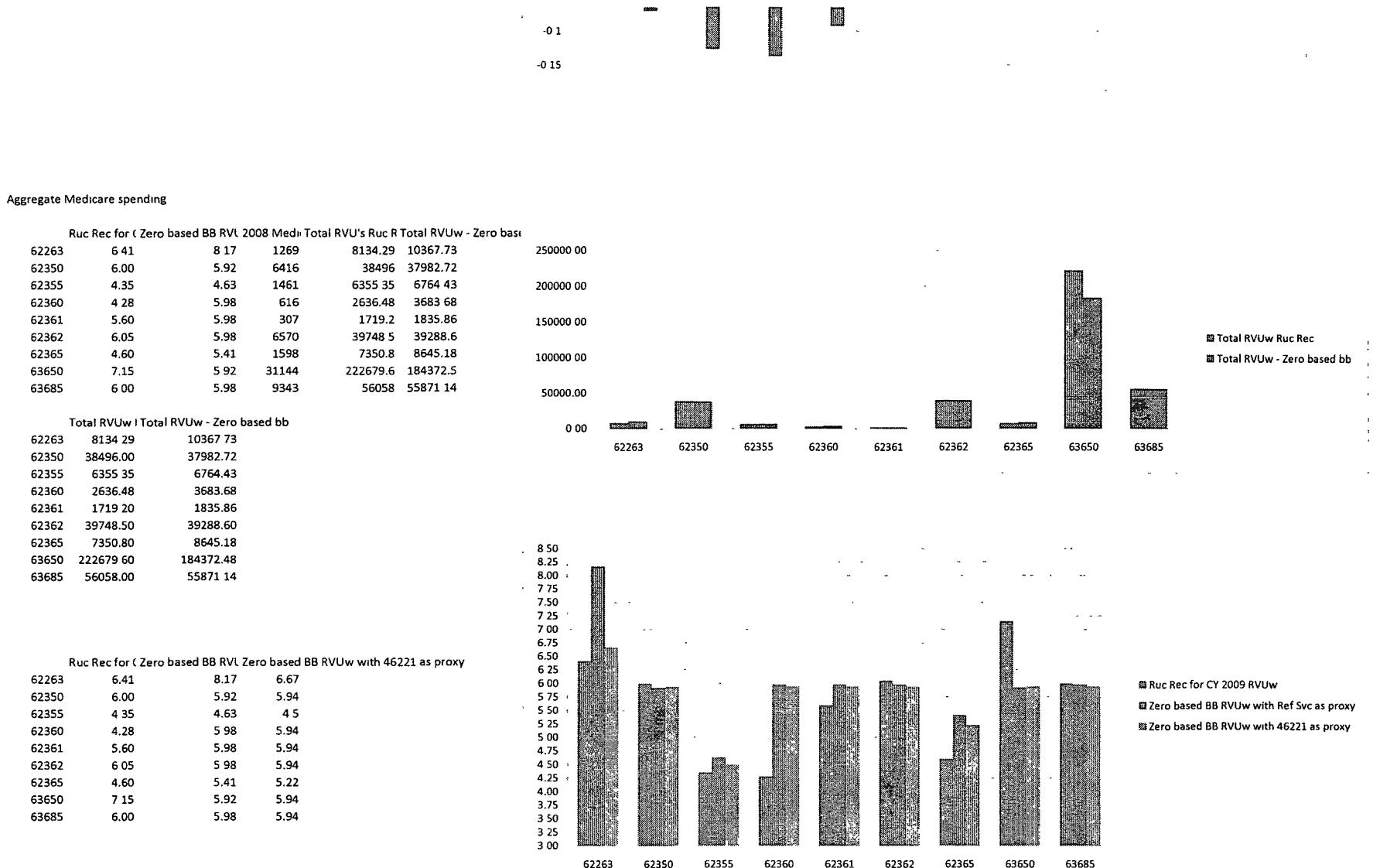
CY2008 IWPI RUC Rec for 2009 Zero based BB IPUT

	0.046	0.043	0.0813
62263	-0.069	0.05	0.0476
62350	-0.126	0.043	0.0523
62355	-0.136	0.026	0.0486
62360	-0.092	0.043	0.0486
62361	-0.062	0.051	0.0486
62362	0.11	0.024	0.0522
62365	0.017	0.069	0.0476
63650	0.026	0.05	0.0486

zero based BB with reference service as intraservice proxy



- CY2008 IPUT
- RUC Rec for 2009 IPUT
- Zero based BB IPUT



Pain codes from Table 15 of 2011 NPMR		62263	62350	62355	62360	62361	62362	62363	63650	63685
		Percutaneous use of epidural sedation during infusion of hyperbaric saline, nitrous or inhaled anesthetic (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesions/sessions, 2 or more days	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long term medication administration via an external pump or implantable reservoir/infusion pump, without laminectomy	Removal of previously implanted device for intrathecal or epidural drug infusion, subcutaneous reservoir	Implantation or replacement of device for intrathecal or epidural drug infusion, nonprogrammable pump	Implantation or replacement of device for intrathecal or epidural drug infusion, programmable pump, including preparation of pump, with or without programming	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	Percutaneous implantation of neurostimulator electrode array, epidural	Implantation/replacement of selected neuromodulatory pads, expanders or reservoirs, direct or indirect, 2 or more days	
CY2008 RVU "starting value"		6.41	8.04	6.60	3.68	6.59	8.58	6.57	7.57	7.87
RUC Rec for CY2009		6.41	6.00	4.35	4.28	6.60	6.05	4.60	7.15	6.00
CY2010 Work RVU		6.54	6.05	4.35	4.35	6.65	6.10	4.65	7.20	6.05
CY2011 Rev BB		6.99	0.41	-0.43	-3.14	-0.92	-0.51	-0.35	4.25	4.80
Global		10	10	10	10	10	10	10	10	10
	Intensity	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time
Pre-Service										
Evaluation	0.0224	0.33	0.07392	33	0.7392	33	0.7392	33	0.7392	33
Positioning	0.0224	10	0.224	10	0.224	10	0.224	10	0.224	10
SDW	0.0081	5	0.0405	5	0.0405	5	0.0405	5	0.0405	5
Intra-Service	(using intra-service intensity of ref svc)	45	3.654	60	2.856	30	1.565	60	2.922	60
Reference Service		62364	64561	62569	61888	61888	61888	64561	61888	61888
Post-Service										
Immed Post-Service	0.0224	20	0.448	20	0.448	20	0.448	20	0.448	20
Visits in Global Period										
99291	4.5000	0	0	0	0	0	0	0	0	0
99292	2.2500	0	0	0	0	0	0	0	0	0
99233	2.0000	0	0	0	0	0	0	0	0	0
99232	1.3900	0	0	0	0	0	0	0	0	0
99231	0.7600	0	0	0	0	0	0	0	0	0
99238	1.2800	0.5	0.64	0.5	0.64	0.5	0.64	0.5	0.64	0.5
99239	1.9000	0	0	0	0	0	0	0	0	0
99215	2.1100	0	0	0	0	0	0	0	0	0
99214	1.5000	0	0	0	0	0	0	0	0	0
99213	0.9700	1	0.97	1	0.97	1	0.97	1	0.97	1
99212	0.4800	1	0.48	0	0	0	0	0	0	0
99211	0.1800	0	0	0	0	0	0	0	0	0
TOTAL with zero based BB		6.17	5.92	4.63	5.98	5.98	5.98	5.92	5.92	5.98
2010 INPUT		0.0451	0.0498	0.0429	0.0211	0.0431	0.0506	0.0355	0.6900	0.0498
INPUT with zero based BB total		0.0413	0.04764	0.03228	0.04864	0.04864	0.04864	0.05218	0.04764	0.04864
TOTAL		0.00	0.00	0.00	5.92	5.92	5.92	0.00	0.00	3.05

To validate using intra-service proxy when survey responses indicated that many respondents selected a reference service other than the key ref svc

100% of 1000

Pain codes from Table 15 of 2011 NPRM		62263	62350	62355	62360	62361	62362	62365	63650	63681
		Percutaneous lytic of epidural adhesions, using solution injection (eg, hypertonic saline, enzymes) or mechanical means (eg, catheter) (including radiologic localization) (includes contrast when administered); multiple subsequent procedures on same day	Implantation revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump, without laminectomy	Removal of previously implanted intrathecal or epidural catheter	Implantation or replacement of device for intrathecal or epidural drug infusion, subcutaneous reservoir	Implantation or replacement of device for intrathecal or epidural drug infusion, nonprogrammable pump	Implantation or replacement of device for intrathecal or epidural drug infusion, programmable pump, including preparation of pump, with or without programming	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	Percutaneous implantation of neurostimulator electrode array, epidural	Insertion or replacement of spinal neurostimulator pulse generator, including receiver, detector or inductive coupling
CY2008 RVU "starting value"		6.41	8.04	6.60	3.68	6.59	8.58	6.57	7.57	7.07
RUC Rec for CY2009		6.41	6.00	4.95	4.28	5.60	6.05	4.60	7.15	6.00
CY2010 Work RVU		6.54	6.05	5.35	4.35	5.65	6.10	4.65	7.20	6.05
CY2011 Rev BB		6.59	0.41	-0.43	-3.14	-0.92	-0.51	-0.35	4.25	4.60
Cross-specialty validation code from MPC list										
Pre service total		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Post service total		3.51	2.06	2.06	2.06	2.06	2.06	2.06	2.06	2.06
Intra service proxy	Code 46221 IINPUT 0479	2.16	2.87	1.44	2.87	2.87	2.87	2.16	2.87	2.87
TOTAL		6.67	5.94	4.50	5.94	5.94	5.94	5.22	5.94	5.94

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Last Year Before RUC Review	2008 RVU	Pre-Service Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07 10.03	2008 2010	75 1,123	75 60	10	15	75 85	120 90	43 30	2 2	2 2	1 1	1 1	1 1	1 1	1 1	1 1	428	0.0145	AAOMS	Pre-RUC Evaluation Post-RUC Evaluation
23415	RELEASE OF SHOULDER LIGAMENT	10.09 9.23	2008 2010	49 1,237	49 40	15	15	49 70	62 60	23 20	3.5 2.0	0.5 2.0	1 1	1 1	0.5 247	0.0866 0.0648	AAOS	Pre-RUC Evaluation Post-RUC Evaluation				
25116	REMOVE WRIST/FOREARM LESION	7.38	2009	36				36	78	21	50		15		1.0	283	0.0192	ASSH, AAOS, ASPS	Pre-RUC Evaluation			
27792	TREATMENT OF ANKLE FRACTURE	7.91 9.71	2007 2010	21 6,020	25 40	10	15	83 65	19 60	4.0 20	1.5 2.0	1.5 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	281	0.0513	AAOS, AOFAS	Pre-RUC Evaluation Post-RUC Evaluation	
28120	PART REMOVAL OF ANKLE/HEEL	5.64 8.27	2009 2010	47 3,851	47 33	10	15	47 58	67 50	21 20	3.5 3.0	1.5 2.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	259	0.0056	AAOS, APMA	Pre-RUC Evaluation Post-RUC Evaluation	
28122	PARTIAL REMOVAL OF FOOT BONE	7.56 7.72	2009 2010	43 10,359	43 33	10	15	43 58	51 50	26 20	5.0 3.0	1.5 2.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	268	0.0304	AAOS, APMA	Pre-RUC Evaluation Post-RUC Evaluation	
28725	FUSION OF FOOT BONES	11.97	2009	50				50	89	22	4.0		2.5		1.0	313	0.0631	AOFAS, APMA	Pre-RUC Evaluation			
28725	FUSION OF FOOT BONES	12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0	1.0	1.0	1.0	1.0	339	0.0496	AAOS	Post-RUC Evaluation	
28730	FUSION OF FOOT BONES	12.21	2009	60				60	120			5.0		1.0	1.0	1.0	1.0	1.0	383	0.0331		Pre-RUC Evaluation
28730	FUSION OF FOOT BONES	12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0	1.0	1.0	1.0	1.0	349	0.0471	AAOS	Post-RUC Evaluation	
28825	PARTIAL AMPUTATION OF TOE	3.71	2008	17				25	42	36	16	3.5		0.5	1.0	1.0	1.0	1.0	198	0.0151	ACS, SVS, APMA	Pre-RUC Evaluation
36821	AV FUSION DIRECT ANY SITE	6.01 9.15	2010 2008	9,014 29	33 25	10	15	58 54	30 75	20 28	2.0 2.5	1.5 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	1.0 1.0	224	0.0099	AAOS	Post-RUC Evaluation	
36821	AV FUSION DIRECT ANY SITE	12.11	2010	34,130	33	10	15	53	90	20	2.0	3.0	1.0	1.0	1.0	1.0	1.0	265	0.0540	SVS, RPA	Pre-RUC Evaluation Post-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAPH	10.00	2009	56				56	81	22	2.5	1.0	1.0	1.0	1.0	1.0	1.0	257	0.0663	ACS, SVS, APMA	Pre-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAPH	15.13	2010	4,873	40	10	15	58	30	20	2.0	2.0	1.0	1.0	1.0	1.0	1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation	
42415	EXCISE PARTOID GLAD/LESION	17.99	2009	55				55	156	37	3.5	1.5	1.0	1.0	1.0	1.0	1.0	396.5	0.0671	ACR, AAO-HNS	Pre-RUC Evaluation Post-RUC Evaluation	
42420	EXCISE PARTOID GLAD/LESION	18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0	1.0	1.0	1.0	1.0	1.0	342	0.0843	ACR, AAO-HNS	Post-RUC Evaluation	
42420	EXCISE PARTOID GLAD/LESION	20.87	2009	57				57	182	22	3.5	3.0	1.0	1.0	1.0	1.0	1.0	439.5	0.0687	ACR, AAO-HNS	Pre-RUC Evaluation	
42440	EXCISE SUBMAXILLARY GLAND	21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0	1.0	1.0	1.0	1.0	432	0.0743	ACR, AAO-HNS	Post-RUC Evaluation	
42440	EXCISE SUBMAXILLARY GLAND	7.05	2009	47				47	71	19	1.5		0.5	1.0	1.0	1.0	1.0	209	0.0500		Pre-RUC Evaluation	
49507	PRP II/HERN INIT BLOCK >5 YR	7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0	1.0	1.0	1.0	1.0	1.0	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation	
49507	PRP II/HERN INIT BLOCK >5 YR	9.97	2009	45				45	67.5	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	239.5	0.0711		Pre-RUC Evaluation	
49521	REREPAIR ING HERNIA, BLOCKED	10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	260	0.0680	ACR	Post-RUC Evaluation	
49521	REREPAIR ING HERNIA, BLOCKED	12.36	2009	45				45	90	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	262	0.0799		Pre-RUC Evaluation	
49587	RPR UNBIL HERN, BLOCK >5 YR	12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	280	0.0795	ACR	Post-RUC Evaluation	
49587	RPR UNBIL HERN, BLOCK >5 YR	7.96	2009	45				45	60	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	232	0.0465		Pre-RUC Evaluation	
49652	LAP VENT/ABD HERNIA REPAIR	8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	250	0.0459	ACR	Post-RUC Evaluation	
49653	LAP VENT/ABD HERN PROC COMP	12.68	2010	45	15	15	15	75	90	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	292	0.0806	ACR	New Code in 2009	
49654	LAP INC HERNIA REPAIR	16.21	2010	45	15	15	15	75	120	30	2.0	1.0	1.0	1.0	1.0	1.0	1.0	378	0.0726	ACR	New Code in 2009	
49655	LAP INC HERN REPAIR COMP	15.03	2010	45	15	15	15	75	120	30	1.0	1.0	1.0	1.0	1.0	1.0	1.0	362	0.0669	ACR	New Code in 2009	
52341	CYSTO W/URETER STRICTURE TX	6.11	2008	47.5				47.5	60	49								156.5	0.0658		Pre-RUC Evaluation	
52341	CYSTO W/URETER STRICTURE TX	5.35	2010	2,105	45	10	15	70	45	20								135	0.0789	AUA	Post-RUC Evaluation	
52342	CYSTO W/UP STRICTURE TX	6.61	2008	60				60	65	30								175	0.0590		Pre-RUC Evaluation	
52342	CYSTO W/UP STRICTURE TX	5.85	2010	281	40	10	10	60	60	20								140	0.0700	AUA	Post-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	7.31	2008	60				60	90	30								200	0.0504		Pre-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	6.55	2010	37	45	10	10	65	60	25								150	0.0780	AUA	Post-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.81	2008	60				60	77.5	30								187.5	0.0650		Pre-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.05	2010	2,447	40	10	10	60	45	20								125	0.1200	AUA	Post-RUC Evaluation	
52345	CYSTO/URETERO W/UP STRICTURE	8.31	2008	50				50	90	30								190	0.0640		Pre-RUC Evaluation	
52345	CYSTO/URETERO W/UP STRICTURE	7.55	2010	475	45	10	15	70	45	20								135	0.1277	AUA	Post-RUC Evaluation	
52346	CYSTOURERETO W/RENAL STRICT	9.34	2008	45				45	120	49								214	0.0603		Pre-RUC Evaluation	
52346	CYSTOURERETO W/RENAL STRICT	8.58	2010	144	40	10	10	60	60	20								140	0.1155	AUA	Post-RUC Evaluation	
52400	CYSTOURERETO W/CONGEN REPR	10.06	2008	90				90	60	30								261	0.0727		Pre-RUC Evaluation	
52400	CYSTOURERETO W/CONGEN REPR	8.69	2010	635	72.5	10	15	97.5	40	25	1.0	1.0	1.0	1.0	0.5	197.5	0.1260	AUA	Post-RUC Evaluation			
52500	REVISION OF BLADDER NECK	9.39	2008	40				40	45	35								247	0.0613		Pre-RUC Evaluation	
52500	REVISION OF BLADDER NECK	8.14	2010	5,348	45	10	15	70	45	27.5								230.5	0.0582	AUA	Post-RUC Evaluation	
52640	RELIEVE BLAD CONTRA	6.59	2008	50				50	30	17.4								216	0.0509		Pre-RUC Evaluation	
52640	RELIEVE BLAD CONTRA	4.79	2010	2,217	40	10	10	60	30	20	2.0	2.0	2.0	2.0	0.5	161	0.0514	AUA	Post-RUC Evaluation			

Tables 15 & 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review		
53445	INSERT URO/VES NCK SPHINCTER	15.21	2009	15.39	50	15	20	75	126	24									1.0	392	0.0546	Pre-RUC Evaluation		
		15.39	2010	1,949	50	15	20	85	90	25	1.0	30			1.0	1.0	1.0	1.0	418	0.0572	AUA	Post-RUC Evaluation		
54410	REMOVE/REPLACE PENIS PROSTH	16.48	2008	15.18	50	10	15	50	145	30									1.0	369	0.0635	Pre-RUC Evaluation		
		15.18	2010	1,328	40	10	15	65	120	30	1.0	30							1.0	338	0.0716	AUA	Post-RUC Evaluation	
54530	REMOVAL OF TESTIS	9.31	2008	8.46	58			58	58	17									1.0	238.5	0.0673	Pre-RUC Evaluation		
		8.46	2010	1,426	57.5	10	15	82.5	60	30	2.0	1.0							0.5	246.5	0.0597	AUA	Post-RUC Evaluation	
57287	REVISE/REMOVE SLING REPAIR	11.49	2008	11.15	45			45	70	30	1.0	20							1.0	285	0.0656	Pre-RUC Evaluation		
		11.15	2010	1,795	40	10	10	60	60	20	1.0	30							0.5	244	0.0691	AUA, ACOG	Post-RUC Evaluation	
61885	INSRT/REDO NEUROSTIM ARRAY	11.37	2009	6.44	50			50	60	25									1.0	325	-0.027	Pre-RUC Evaluation		
		6.44	2010	4,368	39	3	15	51	45	20									0.5	181	0.0567	AANS/CNS	Post-RUC Evaluation	
62263	EPIDURAL LYSIS MULT SESSIONS	6.41	2009	8.04	40			40	30	20									1.0	200	0.0435	Pre-RUC Evaluation		
		6.54	2010	1,269	33	10	5	48	45	20	1.0	2.0							0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation	
62350	IMPLANT SPINAL CANAL CATH	8.04	2008	6.05	70			70	60	125	4.0								1.0	2.0	1.0	487	-0.0715	Pre-RUC Evaluation
		6.05	2010	6,416	33	10	5	48	60	20									0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation	
62355	REMOVE SPINAL CANAL CATHETER	6.60	2008	4.35	60			60	40	130	3.0								1.0	2.0	1.0	446	-0.1284	Pre-RUC Evaluation
		4.35	2010	1,461	33	10	5	48	30	20									0.5	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation	
62360	INSERT SPINE INFUSION DEVICE	3.68	2008	6.59	60			60	55	123	4.0								2.0	1.0	450	-0.1385	Pre-RUC Evaluation	
		4.33	2010	616	33	10	5	48	60	20								1.0	170	0.0211	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation		
62361	IMPLANT SPINE INFUSION PUMP	5.65	2010	6.59	33	10	5	48	60	20									0.5	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation	
		8.58	2008		75			75	90	150	4.0								3.0	1.0	582	-0.0629	Pre-RUC Evaluation	
62362	IMPLANT SPINE INFUSION PUMP	6.10	2010	6,570	33	10	5	48	60	20								1.0	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation		
		6.57	2008		60			60	45	125	3.0								1.0	2.0	1.0	446	-0.1123	Pre-RUC Evaluation
62365	REMOVE SPINE INFUSION DEVICE	4.65	2010	1,598	33	10	5	48	45	20								1.0	155	0.0353	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation		
		7.57	2008		56			56	74	19								2.0	2.5	1.0	283	0.0152	Pre-RUC Evaluation	
63650	IMPLANT NEUROELECTRODES	7.20	2010	31,144	33	10	5	48	60	20								1.0	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation		
		7.87	2008		53			53	62	18								2.0	2.5	1.0	267	0.0245	Pre-RUC Evaluation	
63685	INSRT/REDO SPINE N GENERATOR	6.05	2010	6.22	9,343	33	10	5	48	60	20							1.0	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation		
		209		46				46	76	18	2.5							0.5	1.0	228	0.0301	Pre-RUC Evaluation		
64708	REVISE ARM/LEG NERVE	6.36	2010	10.23	3,069	35	10	10	55	60	15	3.0	1.0						0.5	220	0.0314	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation	
		2008		50				50	74	21								2.5	1.0	260.5	0.0612	Pre-RUC Evaluation		
64831	REPAIR OF DIGIT NERVE	9.16	2010	14.43	972	40	10	15	65	60	15	2.0	2.0						0.5	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation	
		2009		52				52	79	32								5.5	0.5	1.0	337.5	0.0730	Pre-RUC Evaluation	
65285	REPAIR OF EYE WOUND	14.71	2010	14.71	1,154	37		15	52	79	32							5.5	0.5	1.0	337.5	0.0766	AAO	Post-RUC Evaluation

Codes to be reviewed on the Enriched Year Review Appendix E-26-10-0004 57387, 8th report, May 2010, Submission #61885

23+ Hour Services to be reviewed in February, 2011 after CMS releases Final Rule decision regarding subsequent observation codes/value

\*2010 Post- RUC Review work RVUs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10.

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11179 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).
- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	- 0.44 RVUs	0.38 RVUs ..	- 0.76 RVUs	- 1.39 RVUs	- 0.64 RVUs	- 0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39)$

$$- 0.64 - 0.36 = 8.08$$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insr/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil herni, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insr/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IWPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IWPUT is counterintuitive to the IWPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2008

### Epidural Lysis

CPT code 62263 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days* was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The RUC reviewed 62263 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days*. The specialty societies presented data from 19 pain medicine physicians, neurosurgeons, aesthetologists and spine surgeons. The RUC compared the survey code to the reference code, 62264 *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day* (Work RVU=4.42). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 194 minutes and 109 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the ASC or outpatient setting as the 2-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. The RUC determined that after an analysis of the survey intensity measures as compared with the reference code and of the calculated IWPUT of 62263 using the specialties recommended values and times (Current IWPUT=0.046, New IWPUT=0.043), the current work RVU for this service is correct. Therefore, given the comparison to the reference code and the survey data, the RUC determined that the current work RVU for this service was appropriate. **The RUC recommends 6.41 RVUs for 62263.**

**Practice Expense:**

The practice expense inputs, specifically for the assist physician time, discharge day management and the number and level of office visits for 62263 are recommended to be modified to reflect the current survey data.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda- tion
62263		Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days	010	6.41 (No Change)

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:62263      Tracking Number  
 Global Period: 010

Specialty Society Recommended RVU: **6.41**  
 RUC Recommended RVU: **6.41**

**CPT Descriptor:** Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 35-year-old male has severe pain (rated 8/10) located in the right lower back and radiates down the outside of the right leg to the top of the foot and the big toe after multiple back operations over a 10-year period. Various systemic medications (oral narcotic and non-narcotic) and physical therapy have failed to provide significant long-term pain relief. A catheter is placed percutaneously in the epidural space; and epidurogram is performed to identify the areas of scar, nerve constriction and possible nerve inflammation and degree of fluid flow (or lack thereof) in the epidural space; and the epidural adhesions are lysed. [Please note that the catheter is left in place for additional adhesiolysis sessions over the next one or more days. This service encompasses 2 or more days and has a global period of 10 days.]

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 63%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 37%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

Review of records and any pertinent imaging studies (e.g., spine MRI); examine patient for evidence of a single nerve root or spinal nerve dysfunction; communicating with other professionals, patient, and family; and obtaining consent. Pre-operative orders are written to include prophylactic antibiotics. The surgical site is marked. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure, positioning the patient on the x-ray table, and draping of the catheter puncture site.

**Description of Intra-Service Work:**

Time out is conducted with the appropriate personnel and administration of antibiotic is confirmed. The skin is locally anesthetized. The introduction needle is directed into the epidural space at the proper vertebral level or the caudal epidural space, under x-ray fluoroscopy. A flexible catheter is introduced through the needle into the epidural space. The catheter tip is carefully maneuvered in the epidural space around bands of scar tissue until it is in the focal scar tissue at the target spinal nerve-nerve root. A contrast injection is performed to confirm needle tip or catheter location and determine degree of free flow liquid in the epidural space (e.g., determine areas of scarring in the epidural space). This injection also is used with temporary fluorogram monitor views to evaluate the nerve roots and spinal nerves in the area and any focal constriction or swelling of the nerve. The free flow of dye through the epidural space adjacent to this target spinal nerve nerve root is also determined. A decision on the number, type, and quantity of injections/infusions is made. For the typical patient described above, an injection is given at this point of hyaluronidase, local anesthetic, and steroid, followed 30 minutes later by an injection of hypertonic (10%) saline. The catheter exit site is dressed for sterility and secured. At 12-24 hours and at 24-48 hours later, injections are repeated, using local anesthetic, hyaluronidase, steroid, and hypertonic saline. Also, at each series of injections, a repeat epidural contrast injection is performed with temporary fluorogram

monitor views to verify correct catheter placement. Also evaluated is the surrounding epidural space, including the gradual opening of constricted scar areas around the target nerves/nerve roots. After the third series of injections, the catheter is removed and a sterile dressing applied.

**Description of Post-Service Work:**

The patient is closely observed for one to two hours after each injection/infusion, for any new/ unexpected neurologic defects. An operative report is dictated. The physician communicates findings with the patient and other professionals (including written and telephone reports and orders). Post procedure instructions are given to the patient. Additionally, follow-up office visits are scheduled within the 10-day global period to monitor the patient for clinical response to the procedure and for wound care.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	01/2008				
Presenter(s):	Eduardo Fraifeld, MD, Tripti Kataria, MD, MPH, Alexander Mason, MD, Charles Mick, MD, Andrea Trescot, MD				
Specialty(s):	AAPM, ASA, AANS/CNS, NASS, ASIPP				
CPT Code:	62263				
Sample Size:	6700	Resp N:	19	Response: 0.2 %	
Sample Type:	Panel				
	<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate	0.00	0.00	0.00	1.00	40.00
Survey RVW:	4.10	4.66	5.00	6.21	10.00
Pre-Service Evaluation Time:			50.0		
Pre-Service Positioning Time:			15.0		
Pre-Service Scrub, Dress, Wait Time:			15.0		
Intra-Service Time:	15.00	38.00	45.00	60.00	120.00
Immediate Post Service-Time:	<u>15.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.50	99239x 0.00		
Office time/visit(s):	<u>62.0</u>	99211x 0.0	12x 1.0	13x 2.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	62263				
		<u>Specialty Recommended</u>			
Physician Work RVU:		6.41			
Pre-Service Evaluation Time:		33.0			
Pre-Service Positioning Time:		10.0			
Pre-Service Scrub, Dress, Wait Time:		5.0			
Intra-Service Time:		45.00			
Immediate Post Service-Time:	<u>20.00</u>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.5	99239x 0.0		
Office time/visit(s):	<u>62.0</u>	99211x 0.0	12x 1.0	13x 2.0	14x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62264	010	4.42	RUC Time

CPT Descriptor Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
11646	010	10,650	6.21		
<u>CPT Descriptor 1</u> Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm					
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
38510	010	10,207	6.69		

CPT Descriptor 2 Biopsy or excision of lymph node(s); open, deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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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: 78.9 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 62263	<u>Key Reference CPT Code:</u> 62264	<u>Source of Time</u> RUC Time
Median Pre-Service Time	48.00	40.00	
Median Intra-Service Time	45.00	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	19.0	19.00	
Median Office Visit Time	62.0	0.00	

Prolonged Services Time	0.0	0.00
Median Total Time	194.00	109.00
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	3.13
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	3.20
--	------	------

Urgency of medical decision making	2.20	2.13
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.53	3.53
--------------------------	------	------

Physical effort required	2.87	2.80
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.20	3.13
---	------	------

Outcome depends on the skill and judgment of physician	3.33	3.33
--	------	------

Estimated risk of malpractice suit with poor outcome	3.33	3.33
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<b><u>INTENSITY/COMPLEXITY MEASURES</u></b>	<b><u>CPT Code</u></b>	<b><u>Reference Service 1</u></b>
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**Time Segments (Mean)**

Pre-Service intensity/complexity	3.29	3.33
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Intra-Service intensity/complexity	3.64	3.60
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Post-Service intensity/complexity	2.71	2.80
-----------------------------------	------	------

**Additional Rationale**

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

The RUC's Five Year Review Identification Workgroup flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but claims data from recent years show that it is more frequently performed in an ASC or outpatient setting.

As an interim measure, the RUC recommended removing the hospital visits and reducing the discharge day from 1.0 to 0.5. It recommended maintaining the current global period and surveying the code.

An analysis of the survey intensity measures – as compared with the reference code - and of the IWPUT using our recommended values and times, does not offer evidence that the current work RVUs are inaccurate. With current times and values (2007), the code has an IWPUT of .046. Our recommendations result in an IWPUT of .043. The median service performance rate for our respondents was zero; this calls into question the validity of the survey valuation, so we looked at other ways to value this service

We validated our recommendation a via building block methodology that picks up from the one the RUC used when evaluating code 62264. If we add the recommended office visits for 62263 to code 62264 we get:

62264	4.42
99213	0.92
99213	0.92
99212	0.45
	6.71

This is further supported by adding two halves of code 62282 –Injection of neurolytic substance – to the one day coded following the method used in the 62264 building block.

62264	4.42
62282	2.33      two halves
	6.75

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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.
- 

## FREQUENCY INFORMATION

CPT Code: 62263

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 62263

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

**Specialty Pain Mgmt/Interventional Pain Mgmt**      **How often? Commonly**

## Specialty Other Specialties How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and that the frequency would be approximately twice that of the Medicare population.

**Specialty Anesthesiology** Frequency 3240 Percentage 54.00 %

Specialty Pain Mgmt/Interventional Pain Mgmt Frequency 1740 Percentage 29.00 %

**Specialty Other Specialties** Frequency 1020 Percentage 17.00 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 2,988  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare claims data from the RUC database.

**Specialty Anesthesiology**      **Frequency 1614**      **Percentage 54.01 %**

**Specialty Pain Mgmt/Interventional Pain Mgmt**      **Frequency 867**      **Percentage 29.01 %**

Specialty Other Specialties Frequency 507 Percentage 16.96 %

Do many physicians perform this service across the United States? Yes

## **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend maintaining the current PLI value for this code.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Code	62263	
Descriptor	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic	
	2007	RUC Approve
Global	90	10
IWPUT	0.046	0.043
RVUw	6.41	6.41
Pre-service eval & positioning time	40.00	43.00
Pre-service scrub, dress, wait time		5.00
Intra-service time	30.00	45.00
Immediate post time	20.00	20.00
Subsequent visits	99231 x 2	
	99238 x 1	99238 x 0.5
	99212 x 2	99212 x 1
	99213 x 2	

TAB I

63650	To CPT 63660	63685	63688
Percutaneous implantation of neurostimulator electrode array, epidural	Revision or removal of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
2007	RUC Approve	2007	RUC Approve
90	10	90	10
0.017	0.069	0.023	0.051
7.57	7.15	6.87	6.87
31.00	43.00	24.00	24.00
25.00	5.00	25.00	25.00
74.00	60.00	64.00	64.00
19.00	20.00	18.00	18.00
99231 x 2.5		99231 x 1.5	
99238 x 1	99238 x 0.5	99238 x 1	99238 x 0.5
99213 x 2	99213 x 1	99213 x 2	99213 x 2
99212 x 4			

TAB H

Code	62350		62355		Deferred to Apr 62360	62361		62362		RESURVEY 62365	
Descriptor	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	Removal of previously implanted intrathecal or epidural catheter	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without reprogramming	Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion					
	2007	RUC Approve	2007	RUC Approve	2007	Recommend	2007	RUC Approve	2007	RUC Approve	2007
Global	90	10	90	10	90	10	90	10	90	10	90
IWPUT	(0.069)	0.050	(0.126)	0.043	(0.138)	0.026	(0.092)	0.043	(0.062)	0.051	(0.110)
RVUw	8.04	6.00	6.60	4.30	3.68	5.24	6.59	5.60	8.58	6.05	6.57
Pre-service eval & positioning time	70.00	43.00	60.00	43.00	60.00	43.00	60.00	43.00	75.00	43.00	60.00
Pre-service scrub, dress, wait time		5.00		5.00		5.00		5.00		5.00	
Intra-service time	60.00	60.00	40.00	30.00	55.00	60.00	60.00	60.00	90.00	60.00	45.00
Immediate post time	125.00	20.00	130.00	20.00	123.00	20.00	130.00	20.00	150.00	20.00	125.00
Subsequent visits	99233 x 2		99233 x 2		99233 x 2		99233 x 2		99233 x 3		99233 x 2
	99231 x 1		99231 x 1		99238 x 1	99238 x 1	99231 x 1		99238 x 1	99238 x 0.5	99231 x 1
	99238 x 1	99238 x 0.5	99238 x 1	99238 x 0.5	99212 x 4	99213 x 1	99238 x 1	99238 x 0.5	99212 x 4	99213 x 1	99238 x 1
	99212 x 4	99213 x 1	99212 x 3	99213 x 1			99212 x 4	99213 x 1			99212 x 3

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
February and April 2008 – Initial RUC Review

**Intrathecal/Epidural Catheters/Pumps**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT codes 62350, 62355, 62360, 62361, 62362, and 62365, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVUs for this family of codes. The enclosed letter from the specialty examines the flaw in the CMS methodology, explaining that the use of a building block from the ground up (or a zero-based building block methodology) results in different work RVUs. The RUC reviewed the original rationale and several cross-specialty comparisons identified in the initial review. The 2010 work RVUs for this family continued to be supported by these reference service comparisons.

**The RUC recommends the 2010 work RVUs for 6.05 for 62350, 4.35 for 62355, 4.33 for 62360, 5.65 for 62361, 6.10 for 62362, and 4.65 for 62365.**

**February and April 2008 Initial RUC Review**

CPT codes describing intrathecal/epidural catheters/pumps (62350, 62355, 62360, 62361, 62362 and 62365) were identified by the RUC's Five-Year Review Identification Workgroup as site of service anomalies utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that these services are typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated for physician work. CMS further agreed that each of these codes be assigned a 010 global, rather than the 090 day global currently assigned to these services.

**62350 *Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy***

At the February 2008 RUC meeting, the specialty societies presented survey data from 58 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07) and determined that the surveyed code in comparison to the reference code had less total service time, 170 minutes and 204 minutes respectively. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to a one-half discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 6.00 (6.05 in 2010) was appropriate

**62355 *Removal of previously implanted intrathecal or epidural catheter***

At the February 2008 RUC meeting, the specialty societies presented data from 58 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (Work RVU=2.27). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 140 minutes and 79 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to a one-half discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 4.30 work RVUs, or approximately half-way between the median and the 75<sup>th</sup> percentile of the survey data as this value maintains rank order within the family. This value is further supported by another reference code, 44391 *Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU=4.31) as this code and the surveyed code have similar work and total service times, 141 minutes and 140 minutes, respectively. Therefore, given the comparison to the reference codes, the RUC determined that 4.30 (4.35 in 2010) work RVUs was appropriate and maintained rank order within the family of codes.

### **62360 *Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir***

At the April 2008 RUC meeting, the specialty society presented compelling evidence to the RUC in order to consider recommendations to increase the work RVU for 62360. The compelling evidence consists of the change from a 090 global period to a 010 day global considering that the service with the original times and work RVU results in a negative IWP/PUT. The RUC agreed that compelling evidence to consider a change in the work RVU existed because backing out the work associated with the EM services could result in a negative work valuation. Additionally, the specialty noted that incorrect assumptions were made during the original valuation of work by the RUC in 1995, which created a rank order anomaly within the family.

**The RUC approved the compelling evidence to consider a change to the work RVU for 62360.**

The specialty society reviewed the results of a survey of 30 neurosurgeons for 62360. The specialty society adjusted the survey pre-service time to package 2B (difficult patient/straightforward procedure) because they agreed the survey respondents may have overstated the pre-service time. The median intra-service time based on the survey was 60 minutes. The survey median work RVU was 5.00, which the specialty society agreed was too high. The specialty society instead recommended the 25<sup>th</sup> percentile work RVU of 4.28. The RUC found the key reference service 61888, *Revision or removal of cranial neurostimulator pulse generator or receiver* (work RVU = 5.20, intra-service time = 34 minutes) to be similar but commented that it has never been RUC reviewed. The RUC compared the service to another reference service, 36585, *Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access*, (work RVU = 4.81, intra-service time = 60 minutes) and determined the 25<sup>th</sup> percentile RVU placed this code in proper rank order.

### **62361 *Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump***

At the February 2008 RUC meeting, the specialty societies presented data from 37 physicians from pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to a one-half discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies

recommend 5.60 work RVUs, a value between the median and the 75<sup>th</sup> percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 53853 *Transurethral destruction of prostate tissue; by water-induced thermotherapy* (work RVU=5.54) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 5.60 (5.65 in 2010) work RVUs was appropriate and maintained rank order within the family of codes.

**62362 *Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming***

At the February 2008 RUC meeting, the specialty societies presented data from 37 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to a one-half discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 6.05 work RVUs, a value between the median and the 75<sup>th</sup> percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 49570 *Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)* (work RVU=5.97) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 6.10 work RVUs was appropriate and maintained rank order within the family of codes.

**62365 *Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion***

At the April 2008 RUC meeting, the specialty societies requested to re-survey this service as they believe the vignette associated with this service may have caused inaccurate survey data as it referred to the removal and replacement of the reservoir or pump. At the April meeting, the specialty society reviewed the results of a survey of 30 neurosurgeons with the revised clinical vignette. The specialty society noted that this service had originally been brought up in a previous Five-Year Review because of a negative intra-service work per unit of time (IWPUT), but that it was removed because there were not enough survey responses. Based on the results of this survey, the specialty society recommended decreasing the pre-service time from 72 minutes to 48 minutes. This includes the time associated

with pre-service time package 2B with an additional 9 minutes for positioning the patient. The additional positioning time is needed to move the patient from the supine position to a lateral position. This also required placing a pad between the patient's knees, placing the upper arm on a board away from the surgical area, and inserting a foley catheter. The median intra-service time is 45 minutes. The presenters noted that this time is appropriate. The typical patient for this service is taken to the operating room because of an infection, commonly MRSA, and requires the removal of a pump or reservoir. However, the typical service is removal of a pump, rather than reservoir. While the catheter is sometimes removed at the same time, it is separately reportable. However, it is often left in the patient or externalized in order to deliver antibiotics to fight the infection. The pump that requires removal is most commonly held within a cloth sac within the patient. As such, the cloth becomes attached to the fascia with scar tissue and is difficult to remove. The removal must be performed without damaging the catheter. The survey median work RVU was 4.60, which the RUC agreed was appropriate for this service. The RUC also compared the service to reference service, 61888, *Revision or removal of cranial neurostimulator pulse generator or receiver*, (work RVU = 5.20; intra-time = 34 minutes).

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	010	6.05 (no change)
62355	Removal of previously implanted intrathecal or epidural catheter	010	4.35 (no change)
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	010	4.33 (no change)
62361	non-programmable pump	010	5.65 (no change)
62362	programmable pump, including preparation of pump, with or without programming	010	6.10 (no change)

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	010	4.65 (no change)

August 12, 2010

Barbara Levy, MD  
AMA/Specialty Society RVS Update Committee  
515 N. State Street  
Chicago, IL 60654

Re: Codes with site of service anomalies  
Codes 62263 – Tab 66  
Codes 62350, 62355, 62360, 62361, 62362, 62365 – Tab 67  
Codes 63650, 63685 – Tab 68

Dear Dr. Levy:

We are writing to respond to a request from the RUC to provide supplemental support for several RUC recommendations recently reviewed for site of service anomalies. The above-listed codes underwent review in February and April 2008. CMS has requested that the RUC review these services again and in the proposed rule for the 2011 Physician Fee Schedule, CMS notes that it has *"encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies."*

We have applied a "zero-based building block" to the services referenced above. In this approach we started with a value of zero and built upwards. This is in contrast to the "reverse building block" CMS attempted in which they began with a starting value and pulled work out. That approach was clearly flawed as it resulted in a negative work RVU for several of the services to which it was applied.

In our zero-based approach, we used the accepted standards for pre- and post-service work intensities along with the times that were approved by the RUC in 2008. For intra-service complexity, we used the intensity of the reference service with the time the RUC approved for the code under review. When survey respondents were closely divided on their selected reference service, we provide an additional comparison in our attached spreadsheets. We also include a comparison with a code from the MPC list to further validate our values.

We request that the RUC consider the following elements as it reviews our response:

1. If CMS believes that the best way to ensure that the resources required to provide these services are appropriately valued is via a building block (as appears to be the case given the discussion in the Proposed Rule for the 2011 Medicare Physician Fee Schedule in the July 13, 2010 Federal Register), then CMS must be mindful of the vulnerabilities associated with relying solely on a building block. All components must be accurate and validated. In the reverse building block the starting values were certainly an issue.
2. A building block approach cannot capture the complexities, intricacies and subtleties involved in providing medical care. These would include those elements specified in the RUC survey:
  - a. Mental effort and judgment
  - b. Technical skill
  - c. Physical effort
  - d. Psychological stress

Since a building block cannot account for these factors, the zero-based building block arrives as the same value for several of the services to which we applied it even though there are distinctions between the services. These factors can be acknowledged when the services are reviewed by medically and scientifically trained physicians and other qualified providers.

3. The zero-based approach does serve overall to validate the RUC recommendations for these services. This is illustrated in the attached spreadsheet. However, there will be inconsistencies with any methodology and there are two instances where there is some variation between the RUC recommended value and the value derived from the building block:
  - a. Code 62263 - *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days.* As noted in the February 2008 Summary of Recommendation form, the recommended value for this code was already validated with use of two building block approaches. In the first one, the values of the post-procedures visits were added to the value for code 62264 - *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day .*

Code	RVU
62264	4.42
99213	0.92
99213	0.92
99212	.045
<b>TOTAL</b>	<b>6.71</b>

The SOR included additional support by adding two halves of code 62282 - *Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)* to the once day code:

Code	RVU
62264	4.42
62282 x .05	1.165
62282 x .05	1.165
<b>TOTAL</b>	<b>6.75</b>

- b. Code 63650 - *Percutaneous implantation of neurostimulator electrode array, epidural.* There was some difficulty in identifying codes that could serve as reference services for these surveys. Subsequent to the RUC reviews of these codes in February and April 2008, new codes have been established and valued that could serve as more appropriate intra-service proxies than the reference services that were then available. This is particularly germane for code 63650. A better proxy would be code 63663 - *Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including*

*fluoroscopy, when performed - which was reviewed by the RUC in April 2009.*  
Using this as the intra-service proxy would yield a RVUw of 6.19

	Intensity	Time	RVU
Pre Service			
Evaluation	.0224	33 min	0.7392
Positioning	.0224	10 min	0.224
Scrub/Dress/Wait	.0081	5 min	0.0405
Intra-Service (63663 as proxy)	.0521	60 min	3.126
Post-Service			
Immediate post-service	.0224	20 min	0.448
Visits within global period		# of visits	
99238	1.28	.05	0.64
99213	0.97	1.00	0.97
<b>TOTAL</b>			<b>6.187</b>

We believe that this approach does validate the RUC recommended values for these services and we strongly urge the RUC to convey that same conclusion to CMS. We further encourage CMS to accept these recommendations and maintain the current values assigned to these codes.

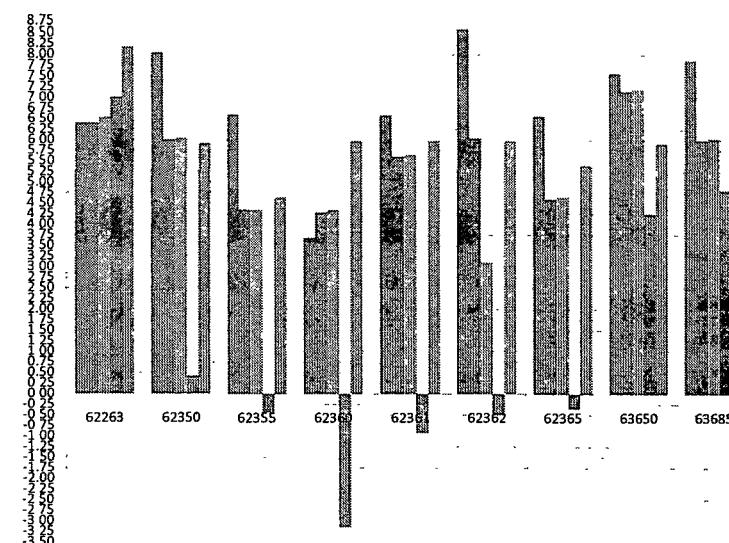
Sincerely,  
American Society of Anesthesiologists  
American Academy of Physical Medicine and Rehabilitation  
North American Spine Society  
American Academy of Pain Medicine  
International Spine Intervention Society  
American Association of Neurological Surgeons  
Congress of Neurological Surgeons

Encl

CY 2008 RVL Ruc Rec for CY 20C CY2010 RV CMS Rev BB RVUw Zero based BB RVUw

62263	6.41	6.41	6.54	6.99	8.17
62350	8.04	6.00	6.05	0.41	5.92
62355	6.60	4.35	4.35	-0.43	4.63
62360	3.68	4.28	4.35	-3.14	5.98
62361	6.59	5.60	5.65	-0.92	5.98
62362	8.58	6.05	3.10	-0.51	5.98
62365	6.57	4.60	4.65	-0.35	5.41
63650	7.57	7.15	7.20	4.25	5.92
63685	7.87	6.00	6.05	4.80	5.98

zero based BB with reference service as intraservice proxy

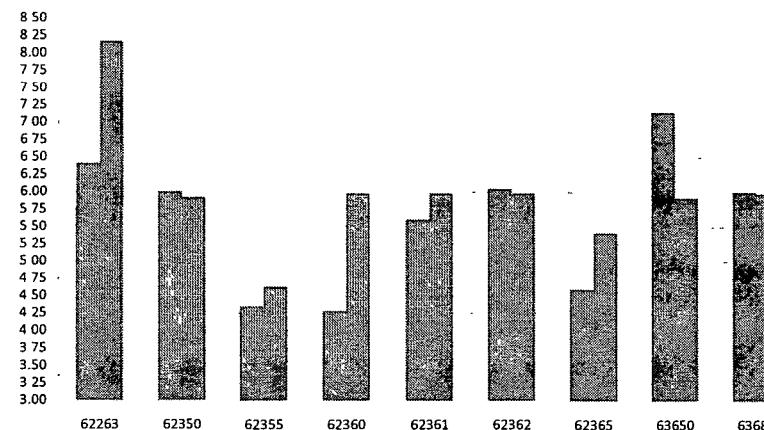


- CY 2008 RVUw
- Ruc Rec for CY 2009 RVUw
- CY2010 RVUw
- CMS Rev BB RVUw
- Zero based BB RVUw

Ruc Rec for CY Zero based BB RVUw

62263	6.41	8.17
62350	6.00	5.92
62355	4.35	4.63
62360	4.28	5.98
62361	5.60	5.98
62362	6.05	5.98
62365	4.60	5.41
63650	7.15	5.92
63685	6.00	5.98

zero based BB with reference service as intraservice proxy

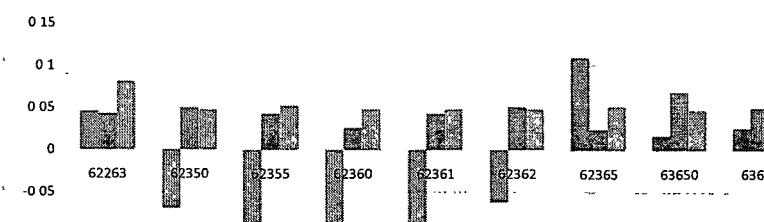


- Ruc Rec for CY 2009 RVUw
- Zero based BB RVUw

CY2008 IPUT RUC Rec for 2009 Zero based BB IPUT

62263	0.046	0.043	0.0813
62350	-0.069	0.05	0.0476
62355	-0.126	0.043	0.0523
62360	-0.136	0.026	0.0486
62361	-0.092	0.043	0.0486
62362	-0.062	0.051	0.0486
62365	0.11	0.024	0.0522
63650	0.017	0.069	0.0476
63685	0.026	0.05	0.0486

zero based BB with reference service as intraservice proxy



- CY2008 IPUT
- RUC Rec for 2009 IPUT
- Zero based BB IPUT

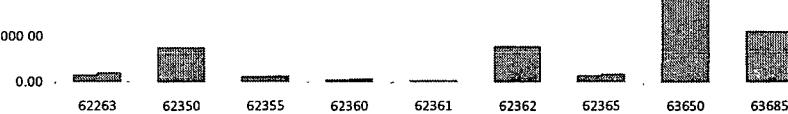


#### Aggregate Medicare spending

	Ruc Rec for CY Zero based BB RVL 2008 Medi	Total RVU's	Ruc R	Total RVUw - Zero bas	
62263	6.41	8.17	1269	8134.29	10367.73
62350	6.00	5.92	6416	38496	37982.72
62355	4.35	4.63	1461	6355.35	6764.43
62360	4.28	5.98	616	2636.48	3683.68
62361	5.60	5.98	307	1719.2	1835.86
62362	6.05	5.98	6570	39748.5	39288.6
62365	4.60	5.41	1598	7350.8	8645.18
63650	7.15	5.92	31144	222679.6	184372.5
63685	6.00	5.98	9343	56058	55871.14
					50000.00

■ Total RVUw Ruc Rec  
■ Total RVUw - Zero based bb

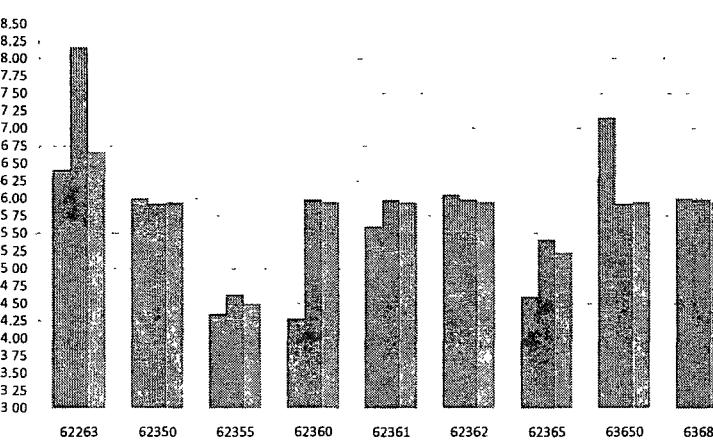
	Total RVUw	Total RVUw - Zero based bb
62263	8134.29	10367.73
62350	38496.00	37982.72
62355	6355.35	6764.43
62360	2636.48	3683.68
62361	1719.20	1835.86
62362	39748.50	39288.60
62365	7350.80	8645.18
63650	222679.60	184372.48
63685	56058.00	55871.14



#### Ruc Rec for CY Zero based BB RVL Zero based BB RVUw with 46221 as proxy

	Ruc Rec for CY Zero based BB RVL	Zero based BB RVUw with Ref Svc as proxy	Zero based BB RVUw with 46221 as proxy
62263	6.41	8.17	6.67
62350	6.00	5.92	5.94
62355	4.35	4.63	4.5
62360	4.28	5.98	5.94
62361	5.60	5.98	5.94
62362	6.05	5.98	5.94
62365	4.60	5.41	5.22
63650	7.15	5.92	5.94
63685	6.00	5.98	5.94

■ Ruc Rec for CY 2009 RVUw  
■ Zero based BB RVUw with Ref Svc as proxy  
■ Zero based BB RVUw with 46221 as proxy



Pain codes from Table 15 of 2011 NPRM		62263	62350	62355	62360	62361	62362	62365	63650	63655
		Percutaneous lysis of epidural adhesions using solution injection (i.e., hyperbaric saline, enzyme) or mechanical means (e.g., catheter), including radiologic localization (includes contrast when administered), multiple adhesions (i.e., location 2 or more days apart)	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump, without laminectomy	Removal of previously implanted, intrathecal or epidural catheter	Implantation or replacement of device for intrathecal or epidural drug infusion, subcutaneous reservoir	Implantation or replacement of device for intrathecal or epidural drug infusion, programmable pump	Implantation or replacement of device for intrathecal or epidural drug infusion, programmable pump, including preparation of pump, with or without programming	Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	Percutaneous implantation of neurostimulator electrode array, epidural	Insertion or replacement of spinal neurostimulator pulse generator, or receiver, direct or inductive coupling
CY2008 RVU "starting value"		8.04	6.60	3.68	3.68	6.59	8.58	6.57	7.57	7.82
RUC Rec for CY2009		6.01	6.00	4.35	4.28	6.60	6.05	4.60	7.15	6.00
CY2010 Work RVU		6.54	6.05	4.35	4.35	6.65	6.10	4.65	7.20	6.05
CY2011 Rev BB		6.99	0.41	-0.43	-3.14	0.97	-0.51	-0.35	4.25	-4.80
Global		10	10	10	10	10	10	10	10	10
	Intensity	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time
Pre-Service										
Eval	0.0224	33	0.7392	33	0.7392	33	0.7392	33	0.7392	33
Positioning	0.0224	10	0.224	10	0.224	10	0.224	10	0.224	10
SDW	0.0081	5	0.0405	5	0.0405	5	0.0405	5	0.0405	5
Intra-Service	(using intra-service intensity of ref svc)	60	2.856	30	1.566	60	2.922	60	2.922	60
Reference Service		62264	64561	64569	61888	61888	61888	64561	61888	64561
Post-Service										
Immed Post-Service	0.0224	20	0.448	20	0.448	20	0.448	20	0.448	20
Visits in Global Period										
99291	4,5000	0	0	0	0	0	0	0	0	0
99292	2,2500	0	0	0	0	0	0	0	0	0
99233	2,0000	0	0	0	0	0	0	0	0	0
99232	1,3500	0	0	0	0	0	0	0	0	0
99231	0,7600	0	0	0	0	0	0	0	0	0
99238	1,2800	0.64	0.5	0.5	0.64	0.5	0.64	0.5	0.64	0.64
99239	1,9000	0	0	0	0	0	0	0	0	0
99215	2,1100	0	0	0	0	0	0	0	0	0
99214	1,5000	0	0	0	0	0	0	0	0	0
99213	0,9700	1	0.97	1	0.97	1	0.97	1	0.97	1
99212	0,4800	1	0.48	0	0	0	0	0	0	0
99211	0,1800	0	0	0	0	0	0	0	0	0
TOTAL with zero based BB		8.17	5.92	4.63	5.98	5.98	5.98	5.92	5.92	5.98
2010 IWP/UT		0.0451	0.0498	0.0429	0.0211	0.0431	0.0506	0.0353	0.6900	0.0498
IWP/UT with zero-based BB total		0.0813	0.04764	0.05228	0.04864	0.04864	0.05218	0.04764	0.04864	0.04864
To validate using intra-service proxy when survey responses indicated that many respondents selected a reference service other than the key ref svc										
Pre service total					1.00	1.00	1.00	1.00	1.00	1.00
Post service total					2.06	2.06	2.06	2.06	2.06	2.06
Intra service proxy					code 64561	2.86 code 64561	2.86 code 61858	2.19		
TOTAL					5.92	5.92	5.92	5.25	0.00	3.06

Pain codes from Table 15 of 2011 NPRM		62263	62350	62355	62360	62361	62362	62365	63650	63685
		Percutaneous trials of epidural or intrathecal analgesics using solution injection (eg, hyperbaric saline; amynal) or mechanical means (eg, catheter), including radiologic localization (includes contrast when administered); multiple anesthesia sessions; 2 or more days	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long term medication administration via an external pump or implantable reservoir/infusion pump, without laminectomy	Removal of previously implanted device for intrathecal or epidural drug infusion subcutaneous reservoir	Implantation or replacement of device for intrathecal or epidural drug infusion subcutaneous reservoir	Implantation or replacement of device for intrathecal or epidural drug infusion, nonprogrammable pump	Implantation or replacement of device for intrathecal or epidural drug infusion, programmable pump, including preparation of pump, with or without programming	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	Percutaneous implantation of neurostimulator electrode array, epidural	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
CY2008 RVU "starting value"		6.41	8.04	6.60	3.68	6.59	8.58	6.57	7.57	7.87
RUC Rec for CY2009		6.41	6.00	4.35	4.28	6.60	6.05	4.80	7.15	6.00
CY2010 Work RVU		6.54	6.05	4.35	4.35	6.65	6.10	4.65	7.20	6.05
CY2011 Rev B8		6.99	0.41	0.43	-3.14	0.092	-0.51	-0.95	4.25	4.80
Cross-specialty validation code from MPC list										
Pre service total			1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Post service total			3.51	2.06	2.06	2.06	2.06	2.06	2.06	2.06
Intra service proxy	Code 46221 INPUT .0479		2.16	2.87	1.44	2.87	2.87	2.16	2.87	2.87
TOTAL			6.67	5.94	4.50	5.94	5.94	5.22	5.94	5.94

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CPT Code	Short Descriptor	Last Year Before RUC Review	Work RVU	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service	99211	99212	99213	99214	99231	99232	99233	99234	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75	10	15		75	120	43	2	2	2	1	1	1	1	428	0.0145		Pre-RUC Evaluation	
		10.03	2010	1,123	60	10	15	85	90	30	2	2						283	0.0530	AAOMS	Post-RUC Evaluation	
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49				49	62	23		3.5		0.5		1	238	0.0886		Pre-RUC Evaluation		
		9.23	2010	1,237	40	15	15	70	60	20	2.0	2.0			0.5	247	0.0648	AAOS	Post-RUC Evaluation			
		7.38	2009		36			36	78	21	5.0		1.5		1.0	283	0.0192		Pre-RUC Evaluation			
25116	REMOVE WRIST/FOREARM LESION	7.56	2010	1,030	40	10	15	65	60	20	1.0	3.0			0.5	249	0.0307	ASSH, AAOS, ASPS	Post-RUC Evaluation			
		7.91	2007		21	25		83	19	4.0		1.5		1.0						Pre-RUC Evaluation		
27792	TREATMENT OF ANKLE FRACTURE	9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0	1.0		1.0	281	0.0513	AAOS, AOFAS	Post-RUC Evaluation			
		5.64	2009		47			47	67	21	3.5		1.5		1.0	259	0.0056		Pre-RUC Evaluation			
28120	PART REMOVAL OF ANKLE/HEEL	8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0	1.0		1.0	280	0.0263	AAOS, APMA	Post-RUC Evaluation			
		7.58	2009		43			43	51	26	5.0		1.5		1.0	268	0.0304		Pre-RUC Evaluation			
28122	PARTIAL REMOVAL OF FOOT-BONE	7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0	1.0		1.0	264	0.0249	AAOS, APMA	Post-RUC Evaluation			
		11.97	2009		50			50	89	22	4.0		2.5		1.0	313	0.0631		Pre-RUC Evaluation			
28725	FUSION OF FOOT BONES	12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0		1.0	339	0.0496	AOFAS, APMA, AAOS	Post-RUC Evaluation			
		12.21	2009		60			60	120		5.0		1.0		1.0	383	0.0331		Pre-RUC Evaluation			
28730	FUSION OF FOOT BONES	12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0		1.0	349	0.0471	AOFAS, APMA, AAOS	Post-RUC Evaluation			
		3.71	2008		17			25	42	36	16	3.5		0.5		1.0	198	-0.0151		Pre-RUC Evaluation		
28825	PARTIAL AMPUTATION OF TOE	6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0			1.0	224	0.0099	AAOS	Post-RUC Evaluation			
		9.15	2008		29			25	54	75	28	2.5		1.5		1.0	265	0.0540		Pre-RUC Evaluation		
36821	AV FUSION DIRECT ANY SITE	12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0			1.0	256	0.0823	ACS, SVS, RPA	Post-RUC Evaluation			
		10.00	2009		56			56	81	22	2.5		1.0		1.0	257	0.0663		Pre-RUC Evaluation			
36825	ARTERY-VEIN AUTOGRAPH	15.13	2010	4,873	40	10	20	70	120	30	1.0	2.0	1.0		1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation			
		17.99	2009		55			55	156	37	3.5		1.5		1.0	396.5	0.0671		Pre-RUC Evaluation			
42415	EXCISE PARTOID GLAD/LESION	18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0			1.0	342	0.0843	ACS, AAO-HNS	Post-RUC Evaluation			
		20.87	2009		57			57	182	22	3.5		3.0		1.0	439.5	0.0687		Pre-RUC Evaluation			
42420	EXCISE PARTOID GLAD/LESION	21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0		1.0	432	0.0743	ACS, AAO-HNS	Post-RUC Evaluation			
		7.05	2009		47			47	71	19	1.5		0.5		1.0	209	0.0500		Pre-RUC Evaluation			
42440	EXCISE SUBMAXILLARY GLAND	7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0			0.5	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation			
		9.97	2009		45			45	67.5	30	1.0	1.0			1.0	239.5	0.0711		Pre-RUC Evaluation			
49507	PRP I/HERN INIT BLOCK >5 YR	10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0	1.0		1.0	260	0.0680	ACS	Post-RUC Evaluation			
		12.36	2009		45			45	90	30	1.0	1.0	1.0		1.0	262	0.0799		Pre-RUC Evaluation			
49521	REREPAIR ING HERNIA, BLOCKED	12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0	1.0		1.0	280	0.0795	ACS	Post-RUC Evaluation			
		7.96	2009		45			45	60	30	1.0	1.0	1.0		1.0	232	0.0465		Pre-RUC Evaluation			
49587	RPR UNBIL HERN, BLOCK >5 YR	8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0	1.0		1.0	250	0.0459	ACS	Post-RUC Evaluation			
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010		45	15	15	75	90	30	1.0	1.0	1.0		1.0	292	0.0806	ACS	New Code in 2009			
49653	LAP VENT/ABD HERN PROC COMP	16.21	2010		45	15	15	75	120	30	2.0	1.0	1.0		1.0	378	0.0726	ACS	New Code in 2009			
49654	LAP INC HERNIA REPAIR	15.03	2010		45	15	15	75	120	30	1.0	1.0	1.0		1.0	362	0.0668	ACS	New Code in 2009			
49655	LAP INC HERN REPAIR COMP	18.11	2010		50	15	15	80	150	30	2.0	1.0	1.0		1.0	413	0.0700	ACS	New Code in 2009			
		6.11	2008		47.5			47.5	60	49						156.5	0.0658		Pre-RUC Evaluation			
52341	CYSTO W/URETER STRICTURE TX	5.35	2010	2,105	45	10	15	70	45	20						135	0.0789	AUA	Post-RUC Evaluation			
52342	CYSTO W/UP STRICTURE TX	6.61	2008		60			60	65	30			1.0			175	0.0590		Pre-RUC Evaluation			
		5.85	2010	281	40	10	10	60	60	20						140	0.0700	AUA	Post-RUC Evaluation			
52343	CYSTO W/RENAL STRICTURE TX	6.55	2010	37	45	10	10	65	60	25						150	0.0780	AUA	Post-RUC Evaluation			
52344	CYSTO/URETERO, STRICTURE TX	7.81	2008		60			60	77.5	30			1.0			187.5	0.0650		Pre-RUC Evaluation			
		7.05	2010	2,447	40	10	10	60	45	20						125	0.1200	AUA	Post-RUC Evaluation			
		8.31	2008		50			50	90	30			1.0			190	0.0640		Pre-RUC Evaluation			
52345	CYSTO/URETERO W/UP STRICTURE	7.55	2010	475	45	10	15	70	45	20						135	0.1277	AUA	Post-RUC Evaluation			
52346	CYSTOURERETO W/RENAL STRICT	9.34	2008		45			45	120	49						214	0.0603		Pre-RUC Evaluation			
		8.58	2010	144	40	10	10	60	60	20						140	0.1155	AUA	Post-RUC Evaluation			
52400	CYSTOURERETO W/CONGEN REPR	10.06	2008		90			90	60	30			1.0	1.0		1.0	261	0.0727		Pre-RUC Evaluation		
		8.69	2010	635	72.5	10	15	97.5	40	25	1.0			0.5	197.5	0.1260	AUA	Post-RUC Evaluation				
52500	REVISION OF BLADDER NECK	8.14	2010	5,348	45	10	15	70	45	27.5			3.0	1.0		0.5	230.5	0.0582	AUA	Post-RUC Evaluation		
		6.89	2008		50			50	39	17.5	2.0					110	0.0509		Pre-RUC Evaluation			
52640	RELIEVE BLAD CONTRAUTURE	4.79	2010	2,217	40	10	10	60	30	20	2.0				105	15	0.0514	AUA	Post-RUC Evaluation			

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CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008		Pre-Service Positioning	Dress scrub and wait time	Total Pre-Service Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99215	99233	99236	99238	Total Time	IWPUT	Specialty Societies	Review		
				Utilization	Evaluation						75	15	20	85	90	25	10	30	1.0	1.0				
53445 INSERT URO/VES NCK SPHINCTER		15.21	2009	1,949	50						75	126	24	99211	99212	99213	99214	99215	1.0	392	0.0546	Pre-RUC Evaluation		
53445 INSERT URO/VES NCK SPHINCTER		15.39	2010								50	90	25						1.0	418	0.0572	AUA		
54410 REMOVE/REPLACE PENIS PROSTH		16.48	2008		50						50	145	30		20	10	10		1.0	369	0.0635	Pre-RUC Evaluation		
54410 REMOVE/REPLACE PENIS PROSTH		15.18	2010		1,328	40		10	15		65	120	30		10	30			1.0	338	0.0716	AUA		
54530 REMOVAL OF TESTIS		9.31	2008		58						58	58	17		2.5	0.5			1.0	238.5	0.0673	Pre-RUC Evaluation		
54530 REMOVAL OF TESTIS		8.46	2010		1,426	57.5		10	15		82.5	60	30		2.0	1.0			0.5	246.5	0.0597	AUA		
57287 REVISE/REMOVE SLING REPAIR		11.49	2008		45						45	70	30		10	20	20		1.0	285	0.0656	Pre-RUC Evaluation		
57287 REVISE/REMOVE SLING REPAIR		11.15	2010		1,795	40		10	10		60	60	20		10	30			0.5	244	0.0912	AUA, ACOG		
61885 INSRT/REDO NEUROSTIM M/T ARRAY		7.37	2009		50						50	60	25		4.0	1.0	10		1.0	325	0.027	Pre-RUC Evaluation		
61885 INSRT/REDO NEUROSTIM M/T ARRAY		6.44	2010		4,368	33		13	15		51	45	20		2.0				0.5	181	0.0567	AANS/CNS		
		6.41	2009			40					40	30	20		2.0				1.0	200	0.0435	Pre-RUC Evaluation		
62263 EPIDURAL LYSIS MULT SESSIONS		6.54	2010		1,269	33		10	5		48	45	20		10	2.0			0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA		
		8.04	2008			70					70	60	125		4.0				1.0	20	1.0	487	-0.0715	Pre-RUC Evaluation
62350 IMPLANT SPINAL CANAL CATH		6.05	2010		6,416	33		10	5		48	60	20			1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS		
		6.60	2008			60					60	40	130		3.0				1.0	20	1.0	446	-0.1284	Post-RUC Evaluation
62355 REMOVE SPINAL CANAL CATHETER		4.35	2010		1,461	33		10	5		48	30	20			1.0			0.5	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS		
		3.68	2008			60					60	55	123		4.0				2.0	1.0	450	-0.1385	Pre-RUC Evaluation	
62360 INSERT SPINE INFUSION DEVICE		4.33	2010		616	33		10	5		48	60	20			1.0			0.5	170	0.0211	AAPMR, ASA, NASS, APM, AANS/CNS		
		6.59	2008			60					60	60	130		4.0				1.0	20	1.0	482	-0.0938	Post-RUC Evaluation
62361 IMPLANT SPINE INFUSION PUMP		5.65	2010		307	33		10	5		48	60	20			1.0			0.5	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS		
		8.58	2008			75					75	90	150		4.0				3.0	1.0	582	-0.0629	Post-RUC Evaluation	
62362 IMPLANT SPINE INFUSION PUMP		6.10	2010		6,570	33		10	5		48	60	20			1.0			0.5	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS		
		6.57	2008			60					60	45	125		3.0				1.0	20	1.0	446	-0.1123	Post-RUC Evaluation
62365 REMOVE SPINE INFUSION DEVICE		4.65	2010		1,598	33		10	5		48	45	20			1.0			0.5	155	0.0353	AAPM, ASA, NASS, APM, AANS/CNS		
		7.57	2008			56					56	74	19		2.0	2.5			1.0	283	0.0152	Post-RUC Evaluation		
63650 IMPLANT NEUROELECTRODES		7.20	2010		31,144	33		10	5		48	60	20			1.0			0.5	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS		
		7.87	2008			53					53	62	18		2.0	2.5			1.0	267	0.0245	Post-RUC Evaluation		
63685 INSRT/REDO SPINE N GENERATOR		6.05	2010		9,343	33		10	5		48	60	20			1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS		
		6.22	2009			46					46	76	18		2.5				1.0	228	0.0301	Post-RUC Evaluation		
64708 REVISE ARM/LEG NERVE		6.36	2010		3,069	35		10	10		55	60	15		3.0	1.0			0.5	220	0.0314	AOFAS, ASSH, AAOS, ASPS		
		10.23	2008			50					50	74	21		2.5				1.0	260.5	0.0612	Post-RUC Evaluation		
64831 REPAIR OF DIGIT NERVE		9.16	2010		972	40		10	15		65	60	15		2.0	2.0			0.5	237	0.0674	AAOS, ASPS, ASSH		
65285 REPAIR OF EYE WOUND		14.43	2009			52					52	79	32		5.5	0.5			1.0	337.5	0.0730	Post-RUC Evaluation		
		14.71	2010		1,154	37		15	52		79	32			5.5	0.5			1.0	337.5	0.0766	AAO		

Codes to be reviewed on the Fourth Five-Year Review Agenda (52610 and 57287) and recent May 2010 Submission (G1885)

23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values

\*2010 Post-RUC Review work RVWs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11719 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC’s recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min ....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	-0.44 RVUs	0.38 RVUs ...	-0.76 RVUs	-1.39 RVUs	-0.64 RVUs	-0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39)$

$$- 0.64 - 0.36 = 8.08$$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Inslt/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Inslt/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IPUT is counterintuitive to the IPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February and April 2008

**Intrathecal/Epidural Catheters/Pumps**

CPT codes describing intrathecal/epidural catheters/pumps (62350, 62355, 62361, 62362 and 62365) were identified by the RUC's Five-Year Review Identification Workgroup as site of service anomalies utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that these services are typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated for physician work. CMS further agreed that each of these codes be assigned a 010 global, rather than the 090 day global currently assigned to these services.

***62350 Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy***

At the February 2008 RUC meeting, the specialty societies presented survey data from 58 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07) and determined that the surveyed code in comparison to the reference code had less total service time, 170 minutes and 204 minutes respectively. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 6.00 was appropriate. **The RUC recommends 6.00 RVUs for 62350.**

***62355 Removal of previously implanted intrathecal or epidural catheter***

At the February 2008 RUC meeting, the specialty societies presented data from 58 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 36589 *Removal of tunneled central venous catheter, without subcutaneous port or pump* (Work RVU=2.27). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had considerably longer total service time, 140

minutes and 79 minutes respectively. Further, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to half a discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 4.30 work RVUs, or approximately half-way between the median and the 75<sup>th</sup> percentile of the survey data as this value maintains rank order within the family. This value is further supported by another reference code, 44391 *Colonoscopy through stoma; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)* (work RVU=4.31) as this code and the surveyed code have similar work and total service times, 141 minutes and 140 minutes, respectively. Therefore, given the comparison to the reference codes, the RUC determined that 4.30 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 4.30 RVUs for 62355.**

**62360 *Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir***

At the April 2008 RUC meeting, the specialty society presented compelling evidence to the RUC in order to consider recommendations to increase the work RVU for 62360. The compelling evidence consists of the change from a 090 global period to a 010 day global considering that the service with the original times and work RVU results in a negative IPUT. The RUC agreed that compelling evidence to consider a change in the work RVU existed because backing out the work associated with the EM services could result in a negative work valuation. Additionally, the specialty noted that incorrect assumptions were made during the original valuation of work by the RUC in 1995, which created a rank order anomaly within the family.

**The RUC approved the compelling evidence to consider a change to the work RVU for 62360.**

The specialty society reviewed the results of a survey of 30 neurosurgeons for 62360. The specialty society adjusted the survey pre-service time to package 2B (difficult patient/straightforward procedure) because they agreed the survey respondents may have overstated the pre-service time. The median intra-service time based on the survey was 60 minutes. The survey median work RVU was 5.00, which the specialty society agreed was too high. The specialty society instead recommended the 25<sup>th</sup> percentile work RVU of 4.28. The RUC found the key reference service 61888, *Revision or removal of cranial neurostimulator pulse generator or receiver* (work RVU = 5.20, intra-service time = 34 minutes) to be similar but commented that it has never been RUC reviewed. The RUC compared the service to another reference service, 36585, *Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access*, (work RVU = 4.81, intra-service time = 60 minutes) and determined the 25<sup>th</sup> percentile RVU placed this code in proper rank order.

**The RUC recommended the survey 25<sup>th</sup> percentile RVU of 4.28 work RVUs for 62360.**

**62361 *Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump***

At the February 2008 RUC meeting, the specialty societies presented data from 37 physicians from pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to half a discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 5.60 work RVUs, a value between the median and the 75<sup>th</sup> percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 53853 *Transurethral destruction of prostate tissue; by water-induced thermotherapy* (work RVU=5.54) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 5.60 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 5.60 RVUs for 62361.**

**62362 *Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming***

At the February 2008 RUC meeting, the specialty societies presented data from 37 pain medicine physicians, neurosurgeons, anesthesiologists and spine surgeons. The RUC compared the survey code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 170 minutes and 171 minutes respectively. However, the RUC noted that the surveyed code required greater mental effort, physical effort and judgment in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting. The respondents indicated that the two 99233 and one 99231 hospital visits, which were previously included in the service's global period, are not included and the full discharge day management service has been reduced to half a

discharge day management service. However, the specialty societies determined that the survey median was not an appropriate value for the service as it would cause rank order anomalies with codes in the family. Therefore, the specialty societies recommend 6.05 work RVUs, a value between the median and the 75<sup>th</sup> percentile of the survey data as this value appropriately maintains rank order within the family. This value is further supported by another reference code, 49570 *Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)* (work RVU=5.97) as this code and the surveyed code have similar work and intra-service times, 60 minutes. Therefore, given the comparison to the reference codes, the RUC determined that 6.05 work RVUs was appropriate and maintained rank order within the family of codes. **The RUC recommends 6.05 RVUs for 62362.**

#### ***62365 Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion***

At the April 2008 RUC meeting, the specialty societies requested to re-survey this service as they believe the vignette associated with this service may have caused inaccurate survey data as it referred to the removal and replacement of the reservoir or pump. At the April meeting, the specialty society reviewed the results of a survey of 30 neurosurgeons with the revised clinical vignette. The specialty society noted that this service had originally been brought up in a previous Five-Year Review because of a negative intra-service work per unit of time (IWPUT), but that it was removed because there were not enough survey responses. Based on the results of this survey, the specialty society recommended decreasing the pre-service time from 72 minutes to 48 minutes. This includes the time associated with pre-service time package 2B with an additional 9 minutes for positioning the patient. The additional positioning time is needed to move the patient from the supine position to a lateral position. This also required placing a pad between the patient's knees, placing the upper arm on a board away from the surgical area, and inserting a foley catheter. The median intra-service time is 45 minutes. The presenters noted that this time is appropriate. The typical patient for this service is taken to the operating room because of an infection, commonly MRSA, and requires the removal of a pump or reservoir. However, the typical service is removal of a pump, rather than reservoir. While the catheter is sometimes removed at the same time, it is separately reportable. However, it is often left in the patient or externalized in order to deliver antibiotics to fight the infection. The pump that requires removal is most commonly held within a cloth sac within the patient. As such, the cloth becomes attached to the fascia with scar tissue and is difficult to remove. The removal must be performed without damaging the catheter. The survey median work RVU was 4.60, which the RUC agreed was appropriate for this service. The RUC also compared the service to reference service, 61888, *Revision or removal of cranial neurostimulator pulse generator or receiver*, (work RVU = 5.20; intra-time = 34 minutes). **The RUC recommends the survey median work RVU of 4.60 for 62365.**

#### **Practice Expense:**

The practice expense inputs, specifically for the discharge day management and the number and level of office visits for 62350, 62355, 62361, 62362, and 62365 are recommended to be modified to reflect the current survey data.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy	010 090	6.00  (Approved at the February 2008 RUC Meeting)
62355	Removal of previously implanted intrathecal or epidural catheter	010 090	4.30  (Approved at the February 2008 RUC Meeting)
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir	010 090	4.28
62361	non-programmable pump	010 090	5.60  (Approved at the February 2008 RUC Meeting)
62362	programmable pump, including preparation of pump, with or without programming	010 090	6.05  (Approved at the February 2008 RUC Meeting)
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	010 090	4.60

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code: 62350      Tracking Number  
 Global Period: 010

Specialty Society Recommended RVU: **6.62**  
 RUC Recommended RVU: **6.00**

CPT Descriptor: Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year-old man has bilateral leg and pelvic pain (rated 8/10) from prostate cancer with wide metastases. The patient has been placed on oral opiates with some pain relief; however, he has experienced intolerable side effects even with low doses of oral opiates. Placement of an intrathecal catheter is planned for the administration of intrathecal opiates and local anesthetics. The catheter will be implanted using a percutaneous approach and then tunneled subcutaneously to connect to an implantable reservoir pump. The implantation of the subcutaneous reservoir or pump is separately reportable. Postoperative hospital care and office visits are conducted as necessary through the 10 day global period.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 50%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 24%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Review chart and medical records

Order and review lab work

Review surgical procedure, post-op recovery in and out of hospital with patient and family

Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient

Position patient on the operating table

Write preoperative orders including prophylactic antibiotics

Verify that all the necessary instruments are available, prepare equipment required for surgery

Obtain informed consent

Identify the appropriate surgical site.

The patient is placed in the lateral or prone position on a radiolucent table, taking care to insure adequate spacing of appropriate interlaminar level. The patient is prepped and draped.

Description of Intra-Service Work:

Time out is conducted with the appropriate personnel and administration of antibiotic is confirmed.

Fluoroscopically the proper level is identified. A Touhy needle is inserted at the correct level and the epidural space is identified or inserted into the intrathecal space. The catheter is advanced using fluoroscopy to the desired placement level and patency is verified by free flow of CSF and/or injection of nonionic contrast. With the Touhy needle in place, a vertical incision (3-5 cm) is made to expose the supraspinous ligament to provide tissue to secure the catheter segment. The Touhy needle and guide are withdrawn. The catheter is secured with a purse string suture around the catheter. An anchoring sleeve to prevent tension and angulation of the catheter is sutured to the tissue and the catheter is inserted into

the sleeve. The catheter is then tunneled to the reservoir or pump and securely connected. The wound is then closed after connection to reservoir or pump.

Description of Post-Service Work:

Post operative orders for recovery room and admission are written.

Post -service includes: patient stabilization; dictating an operative report, communicating with the patient, family, and other health care professionals (including written and telephone reports and orders); and discharge day management. Prescriptions are written upon discharge. Additionally, all hospital visits and post-discharge office visits for care of the wound for 10 days after the day of the operation are considered part of the post-operative work for this procedure.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	01/2008					
Presenter(s):	Tripti Kataria, MD, MPH, Eduardo Fraifeld, MD, Alexander Mason, MD, David Bagnall, MD, Charles Mick, MD					
Specialty(s):	ASA, AAPM, AANS/CNS, ISIS, NASS, AAPM&R					
CPT Code:	62350					
Sample Size:	6700	Resp N:	58	Response: 0.8 %		
Sample Type:	Panel					
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate		0.00	1.00	4.00	10.00	35.00
Survey RVW:		2.00	3.93	6.00	7.38	16.00
Pre-Service Evaluation Time:				50.0		
Pre-Service Positioning Time:				15.0		
Pre-Service Scrub, Dress, Wait Time:				15.0		
Intra-Service Time:		15.00	30.00	60.00	75.00	180.00
Immediate Post Service-Time:	<u>20.00</u>					
Post Operative Visits	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>20.0</u>	99231x 1.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>38.0</u>	99238x 1.00	99239x 0.00			
Office time/visit(s):	<u>23.0</u>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	62350					
		<u>Specialty Recommended</u>				
Physician Work RVU:		6.62				
Pre-Service Evaluation Time:		33.0				
Pre-Service Positioning Time:		10.0				
Pre-Service Scrub, Dress, Wait Time:		5.0				
Intra-Service Time:		60.00				
Immediate Post Service-Time:	<u>20.00</u>					
Post Operative Visits	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.5	99239x 0.0			
Office time/visit(s):	<u>23.0</u>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64561	010	7.07	RUC Time

CPT Descriptor Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
11646	010	10,650	6.21		

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose lips; excised diameter over 4.0 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
38510	010	10,207	6.69		

CPT Descriptor 2 Biopsy or excision of lymph node(s); open , deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 29.3 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 62350	<u>Key Reference CPT Code:</u> 64561	<u>Source of Time</u> RUC Time
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	60.00	70.00	
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	19.0	19.00	
Median Office Visit Time	23.0	40.00	
Prolonged Services Time	0.0	0.00	
Median Total Time	170.00	204.00	

Other time if appropriate		
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### 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	3.13
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.38
--	------	------

Urgency of medical decision making	2.44	2.33
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#### Technical Skill/Physical Effort (Mean)

Technical skill required	3.41	3.19
--------------------------	------	------

Physical effort required	2.47	2.38
--------------------------	------	------

#### Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.06	2.88
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Outcome depends on the skill and judgment of physician	3.71	3.38
--	------	------

Estimated risk of malpractice suit with poor outcome	3.53	3.31
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### INTENSITY/COMPLEXITY MEASURES

CPT Code      Reference  
Service 1

#### Time Segments (Mean)

Pre-Service intensity/complexity	3.12	3.19
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Intra-Service intensity/complexity	3.35	3.25
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Post-Service intensity/complexity	3.35	2.56
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### **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.*

This code was originally brought forth to the 3<sup>rd</sup> Five-year review because of potential miscalculation, but was withdrawn because of inadequate survey response numbers. Subsequently, the RUC's Five Year Review Identification Workgroup flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but recent claims data show it is moving to an outpatient setting.

To address the site of service anomaly on an interim measure, the RUC recommended that the hospital visits be removed, the discharge be reduced from 1.0 to 0.5, and that the code be re-surveyed with a 10 day global period. It currently holds a 90 day global.

Our analysis of the survey's complexity/intensity measures support a work value slightly lower than that of the reference service (code 64561 –Work RVU 7.07). Pre-service time was reduced from 80 to 48 minutes following pre-facilitation. Based on comparisons with time and intensity to the reference service, we are recommending a work RVU of 6.62 with and IWP/UT of 0.049.

## **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. This would be reported in conjunction with code 62362 - Implantation or replacement of device for intrathecal or epidural drug infusion: programmable pump, including preparation of pump, with or without reprogramming. This code is under review at this meeting.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 62350

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Other Specialties How often?

Estimate the number of times this service might be provided nationally in a one-year period? 14000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and that the frequency would be approximately twice that of the Medicare population.

Specialty Anesthesiology Frequency 4760 Percentage 34.00 %

Specialty Neurosurgery Frequency 4200 Percentage 30.00 %

Specialty Other Specialties	Frequency 5040	Percentage 36.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,013  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare claims data from the RUC database

Specialty Anesthesiology	Frequency 2384	Percentage 33.99 %
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Specialty Neurosurgery	Frequency 2104	Percentage 30.00 %
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Specialty Other Specialties	Frequency 2525	Percentage 36.00 %
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Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend maintaining the current PLI value for this code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code: 62355      Tracking Number  
 Global Period: 010

Specialty Society Recommended RVU: **4.94**  
 RUC Recommended RVU: **4.30**

CPT Descriptor: Removal of previously implanted intrathecal or epidural catheter

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year-old man with metastatic cancer of the prostate to multiple bony sites, has had good pain control following implantation of an intrathecal catheter connected to an external pump system. He has developed signs of an infection involving the catheter. The tunneled catheter is removed. Postoperative hospital care and office visits are conducted as necessary through the 10 day global period.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 43%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 17%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Review chart and medical records

Order and review lab work

Pre-operative orders are written as well as orders for prophylactic antibiotics

Review surgical procedure, post-op recovery in and out of hospital with patient and family

Speak to anesthesiologist about expected length of procedure and any special concerns about this particular patient

Position patient on operating table

Verify that all necessary instruments are available,

Prepare equipment required for surgery

Obtain informed consent

Identify the appropriate surgical site

The patient is placed in a lateral position on a radiolucent table taking care to insure adequate spacing of appropriate interlaminar level and access to the reservoir. The patient is then prepped and draped.

Description of Intra-Service Work:

The physician participates in a time out with the operative team.

The previously implanted catheter is removed by re-exploration of the operative tract. This requires reopening the lumbar incision and releasing the anchoring sutures around the catheter. The connection of the spinal catheter to the implanted pump or reservoir is then surgically exposed. The catheter is disconnected from the reservoir or pump. The catheter is then withdrawn from the point of spinal insertion.

Cultures are often taken and sent to pathology. The track is closed to reduce the possibility of CSF leak and all the wound are closed.

Description of Post-Service Work:

An operative report is dictated. Post operative orders for recovery room and admission are written.

CPT Code: 62355

Patient stabilization; communicating with the patient, family, and other health care professionals (including written and telephone reports and orders); and discharge day management. Additionally, all hospital visits and post-discharge office visits for care of the wound for 10 days after the day of the operation are considered part of the post-operative work for this procedure.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2008					
<b>Presenter(s):</b>	Tripti Kataria, MD, MPH, Eduardo Fraifeld, MD, Alexander Mason, MD, David Bagnall, MD, Charles Mick, MD					
<b>Specialty(s):</b>	ASA, AAPM, AANS/CNS, ISIS, NASS, AAMP&R					
<b>CPT Code:</b>	62355					
<b>Sample Size:</b>	6700	<b>Resp N:</b>	58	<b>Response:</b> 0.8 %		
<b>Sample Type:</b>	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	<b>High</b>
<b>Service Performance Rate</b>		0.00	0.00	<b>1.00</b>	3.00	18.00
<b>Survey RVW:</b>		1.45	2.50	<b>3.55</b>	5.15	12.00
<b>Pre-Service Evaluation Time:</b>				<b>45.0</b>		
<b>Pre-Service Positioning Time:</b>				<b>10.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>15.0</b>		
<b>Intra-Service Time:</b>		5.00	20.00	<b>30.00</b>	45.00	120.00
<b>Immediate Post Service-Time:</b>	<b><u>20.00</u></b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<b>0.0</b>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<b>20.0</b>	99231x 1.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<b>38.0</b>	99238x 1.00	99239x 0.00			
Office time/visit(s):	<b>23.0</b>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0	15x 0.0
Prolonged Services:	<b>0.0</b>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

<b>CPT Code:</b>	62355					
		<b>Specialty Recommended</b>				
<b>Physician Work RVU:</b>		<b>4.94</b>				
<b>Pre-Service Evaluation Time:</b>		<b>33.0</b>				
<b>Pre-Service Positioning Time:</b>		<b>10.0</b>				
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.0</b>				
<b>Intra-Service Time:</b>		<b>30.00</b>				
<b>Immediate Post Service-Time:</b>	<b><u>20.00</u></b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<b>0.0</b>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<b>19.0</b>	99238x 0.5	99239x 0.0			
Office time/visit(s):	<b>23.0</b>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0	15x 0.0
Prolonged Services:	<b>0.0</b>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36589	010	2.27	RUC Time

CPT Descriptor Removal of tunneled central venous catheter, without subcutaneous port or pump

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
11646	010	10,650	6.21		
<u>CPT Descriptor 1</u> Excision, malignant lesion including margins, face, ears, eyelids; nose, lips: excised diameter over 4.0 CM					
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
38510	010	10,207	6.69		

CPT Descriptor 2 Biopsy or excision of lymph node(s); open, deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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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: 43.1 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 62355	<u>Key Reference CPT Code:</u> 36589	<u>Source of Time</u> RUC Time
Median Pre-Service Time	48.00	25.00	
Median Intra-Service Time	30.00	13.00	
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	19.0	19.00	
Median Office Visit Time	23.0	7.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	140.00	79.00
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	2.52	2.50
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.48	2.33
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Urgency of medical decision making	3.13	2.74
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.40	2.17
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Physical effort required	2.16	2.13
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.80	2.46
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Outcome depends on the skill and judgment of physician	2.72	2.54
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Estimated risk of malpractice suit with poor outcome	2.92	2.67
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<u>INTENSITY/COMPLEXITY MEASURES</u>	<u>CPT Code</u>	<u>Reference</u>
		<u>Service 1</u>

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.68	2.63
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Intra-Service intensity/complexity	2.48	2.42
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Post-Service intensity/complexity	2.44	2.25
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**Additional Rationale**

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

This code was originally brought forth to the 3<sup>rd</sup> Five-year review because of potential miscalculation, but was withdrawn because of inadequate survey response numbers. Subsequently, the RUC's Five Year Review Identification Workgroup

flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but recent claims data show it is moving to an outpatient setting.

As an interim measure, the RUC recommended that the hospital visits be removed, the discharge be reduced from 1.0 to 0.5 and that the code be re-surveyed with a 10 global period. Currently, a 90 day global period applies.

Pre-service time was reduced from 70 minutes to 48 following pre-facilitation. Survey comparisons show that the code is more complex/intense than the reference service. Based on comparisons with other similar services in the family, we are recommending a work RVU of 4.94 with an IPUT of 0.043.

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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: 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. This would be reported in conjunction with code 62365 - Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion. This code is under review at this RUC meeting.
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## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 62355

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology

How often? Sometimes

Specialty Neurosurgery

How often? Sometimes

Specialty Other Specialties

How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and that the frequency would be the same as the Medicare population

Specialty Anesthesiology	Frequency 528	Percentage 33.00 %
Specialty Neurosurgery	Frequency 496	Percentage 31.00 %
Specialty Other Specialties	Frequency 576	Percentage 36.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,541  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare claims data from the RUC database

Specialty Anesthesiology	Frequency 509	Percentage 33.03 %
Specialty Neurosurgery	Frequency 478	Percentage 31.01 %
Specialty Other Specialties	Frequency 554	Percentage 35.95 %

Do many physicians perform this service across the United States? Yes

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### Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend maintaining the current PLI value for this code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 62360  
Global Period: 010

Tracking Number

Specialty Society Recommended RVU: **5.00**  
RUC Recommended RVU: **4.28**

CPT Descriptor: Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year-old man has bilateral leg and pelvic pain (rated 8/10) from prostate cancer with wide metastases. The patient has been placed on oral opiates with some pain relief; however, he has experienced intolerable side effects even with ultra low doses. The patient had undergone placement of a tunneled epidural catheter (separately reported) and tolerated a trial of epidural opiates. A subcutaneous reservoir for periodic administration of drug into the epidural space is placed and connected to an existing tunneled epidural catheter.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 57%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 27%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

Preoperative orders are written including orders for prophylactic antibiotics.

Pre-service includes: a review of hospital admission workup; communicating with the referring physician and other health care professionals; and obtaining informed consent. Pre-service work also includes pre-operative scrubbing and positioning, prepping, and draping the patient. The patient is placed in the lateral position - axillary roll and pressure point padding is essential to reduce risk of nerve injury

**Description of Intra-Service Work:**

The physician participates in a time out with the operative team.

An abdominal incision is made to create a pocket for the reservoir in the deep subcutaneous layer beneath the skin. A tunneling rod is advanced subcutaneously from the abdominal pocket around to the spinal incision site. The spinal catheter is attached to the tunneling rod and secured with a ligature. The catheter is pulled through to the subcutaneous pocket. The catheter connection is completed at the spinal site by inserting a metal tubing connector, a strain relief sleeve (optional) and placement of ligatures to secure the connection. At the abdominal site, patency of the catheter is confirmed and the catheter is secured with a non-absorbable ligature to the reservoir. The wound is irrigated and the skin incision is closed.

**Description of Post-Service Work:**

Post operative orders are written and operative report dictated.

Post-service includes: patient stabilization; communicating with the patient, family, and other health care professionals (including written and telephone reports and orders); discharge day management and prescriptions are written. Additionally, visits for care of the wound for 10 days after the day of the operation are considered part of the post-operative work for this procedure.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2008				
<b>Presenter(s):</b>	Tripti Kataria, MD, MPH, Eduardo Fraifeld, MD, Alexander, Mason, MD. Rick, Boop, MD, John Wilson, MD, Charles Mick, MD				
<b>Specialty(s):</b>	ASA, AAPM, AANS/CNS, NASS, AAPM&R, ISIS				
<b>CPT Code:</b>	62360				
<b>Sample Size:</b>	6700	<b>Resp N:</b>	30	<b>Response:</b> 0.4 %	
<b>Sample Type:</b>	Panel				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Service Performance Rate</b>		0.00	0.00	<b>0.00</b>	2.00
<b>Survey RVW:</b>		1.50	4.28	<b>5.00</b>	6.00
<b>Pre-Service Evaluation Time:</b>				<b>50.00</b>	
<b>Pre-Service Positioning Time:</b>				<b>15.00</b>	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>15.00</b>	
<b>Intra-Service Time:</b>		20.00	30.00	<b>60.00</b>	75.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b>	99292x <b>0.00</b>		
<b>Other Hospital time/visit(s):</b>	<b>20.00</b>	99231x <b>1.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>	
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x <b>1.00</b>	99239x <b>0.00</b>		
<b>Office time/visit(s):</b>	<b>23.00</b>	99211x <b>0.00</b>	12x <b>0.00</b>	13x <b>1.00</b>	14x <b>0.00</b>
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>	57x <b>0.00</b>

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	62360	<b>Recommended Physician Work RVU: 5.00</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		<b>33.00</b>	<b>33.00</b>	<b>0.00</b>
<b>Pre-Service Positioning Time:</b>		<b>10.00</b>	<b>1.00</b>	<b>9.00</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.00</b>	<b>5.00</b>	<b>0.00</b>
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x <b>0.00</b>	99292x <b>0.00</b>	
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x <b>0.00</b>	99232x <b>0.00</b>	99233x <b>0.00</b>
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x <b>0.5</b>	99239x <b>0.0</b>	
<b>Office time/visit(s):</b>	<b>23.00</b>	99211x <b>0.00</b>	12x <b>0.00</b>	13x <b>1.00</b>
<b>Prolonged Services:</b>	<b>0.00</b>	99354x <b>0.00</b>	55x <b>0.00</b>	56x <b>0.00</b>

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61888	010	5.20	Harvard Time

CPT Descriptor Revision or removal of cranial neurostimulator pulse generator or receiver

**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.

Most Recent

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
11646	010	6.21	RUC Time	11,014

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 CM

Most Recent

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
38510	010	6.69	RUC Time	9,700

CPT Descriptor 2 Biopsy or excision of lymph node(s); open, deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64561	010	7.07	RUC Time

CPT Descriptor Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)

**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: 43.3 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 62360	<u>Key Reference CPT Code:</u> 61888	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	60.00	34.00	
Median Immediate Post-service Time	20.00	18.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	20.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	23.0	16.00	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>170.00</b>	<b>171.00</b>	
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	2.73
--	------	------

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	2.33	2.18
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.17	3.18
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Physical effort required	2.58	2.45
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.17	2.82
---	------	------

Outcome depends on the skill and judgment of physician	3.33	3.00
--	------	------

Estimated risk of malpractice suit with poor outcome	3.73	3.36
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

**CPT Code**      **Reference**  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	2.91
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Intra-Service intensity/complexity	3.08	3.09
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Post-Service intensity/complexity	2.92	2.55
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**Additional Rationale**

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

This code was originally brought forth to the 3<sup>rd</sup> Five-year review because of potential miscalculation, but was withdrawn because of inadequate survey response numbers. Subsequently, the RUC's Five Year Review Identification Workgroup flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but recent Medicare claims data show it to be moving to an outpatient setting. As an interim measure, the RUC recommended removing the hospital visits, reducing the discharge day from 1.0 to 0.5 and having the code surveyed with a 10 day global period instead of its current 90 day period.

We note the current value of 3.68 with a 90 day global is unreasonable (rank order issues) and its negative IPUT value supports this position. We surveyed this code for presentation at the January 2008 RUC meeting but, since we are requesting an increased RVUw, we deferred presentation until this April 2008 meeting.

The median Survey Performance Rate for the code under review is zero. The Service Performance Rate for the Key Reference Service is:

Low	0.00
25 <sup>th</sup> percentile	0.00
Median	0.00
75 <sup>th</sup> percentile	4.25
High	20.00

We are including a supplemental presentation of the survey results. In Attachment 1, you will find our results broken down into three categories: responses from those who indicated that they have not performed the service in the past year, those who indicated that they had performed it in this time frame, and all responses.

We compare this service to the port-access component of code 36561 - Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older,. Code 36561 has an RVUw of 6.01 while a CVP placement as described by code 36556 - Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older has 2.50 RVUw. This means that the port access work of 36561 would be **3.51** RVUw. The code under review – 62360 – is almost always subject to a modifier 51 reduction so actually payment would be based on **2.30** RVUw (4.60/2)

Pre-service time was reduced from 80 minutes to 48 after pre-facilitation in January. We base pre-service times on package 2B with additional time needed for positioning for the reasons cited in the pre-service work description.

Errors in placement of this device can lead to drug misdelivery and life threatening meningitis.

We are recommending 5.00 RVUw with an IPUT of .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: 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. This code would typically be reported in conjunction with code 62350 - Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy. This code was reviewed at the January 2008 RUC meeting where the RUC recommended: Global = 010; Work RVU = 6.00; Pre-service time 48 min

CPT Code: 62360

(33 min eval, 10 min positioning and 5 min scrub/dress/wait); intra-service time = 60 min; post-service time = 20 min. Within the 10 day global, 99238 x 0.5, 99213 x 1

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 62360

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

### Specialty Other Specialties How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and that the frequency would be approximately twice that of the Medicare population

Specialty Anesthesiology Frequency 353 Percentage 35.30 %

Specialty Neurosurgery Frequency 279 Percentage 27.90 %

Specialty Other Specialties Frequency 368 Percentage 36.80 %

Estimate the number of times this service might be provided to Medicare patients nationally in a one-year period? 526  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Claims data from the RUC database

Specialty Anesthesiology Frequency 186 Percentage 35.36 %

Specialty Neurosurgery Frequency 147 Percentage 27.94 %

Specialty Other Specialties Frequency 193 Percentage 36.69 %

Do many physicians perform this service across the United States? No

## **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend using the values assigned to 62365. We maintain the the code is currently undervalued

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code: 62361      Tracking Number  
 Global Period: 010

Specialty Society Recommended RVU: **6.24**  
 RUC Recommended RVU: **5.60**

CPT Descriptor: Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year-old man has bilateral leg and pelvic pain (rated 8/10) from prostate cancer with wide metastases. The patient has been placed on oral opiates with some pain relief; however, he has experienced intolerable side effects even with ultra low doses. The patient had undergone placement of a tunneled intrathecal catheter (separately reported) and tolerated a trial of intrathecal opiates. A non-programmable pump for continuous administration of drug into the intrathecal space is placed subcutaneously and connected to an existing tunneled intrathecal catheter. Postoperative hospital care and office visits are conducted as necessary through the 10 day global period.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 49%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 19%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

Pre-operative orders are written including prophylactic antibiotics.

The chart is reviewed, the procedure is explained to the patient including risks, benefits, and alternatives to surgery and consent obtained. The patient is marked, positioned and prepped typically in the lateral position with a bean bag support. The physician scrubs and drapes in a standard fashion. The pump is checked and prepared for implantation. The pump is warmed to 35-45 C. Under sterile conditions, the sterile water is removed from the pump and replaced with the required amount of prescribed fluid.

**Description of Intra-Service Work:**

The physician participates in a time out with the operative team.

An abdominal incision is made to create a pocket for the pump in the deep subcutaneous layer beneath the skin. A tunneling rod is advanced subcutaneously from the abdominal pocket around to the spinal incision site. The spinal catheter is attached to the tunneling rod and secured with a ligature. The catheter is pulled through to the subcutaneous pocket. The catheter connection is completed at the spinal site by inserting a metal tubing connector, a strain relief sleeve (optional) and placement of ligatures to secure the connection. At the abdominal site, patency of the catheter is confirmed and the catheter is secured with a non-absorbable ligature to the pump. The pump is secured in the abdominal wall pocket. The skin incision is irrigated and closed and the wound is dressed.

**Description of Post-Service Work:**

The patient is stabilized. Postoperative orders are written and a note is dictated or written and placed in the chart. The operative note is dictated. The physician communicates with the patient, family, and other health care professionals. Discharge instructions are reviewed and follow-up arrangements completed. Prescriptions are written. Office visits for care of the wound for 10 days after the day of the operation are conducted.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2008				
<b>Presenter(s):</b>	Tripti Kataria, MD, MPH, Eduardo Fraifeld, MD, Alexander Mason, MD, David Bagnall, MD, Charles Mick, MD				
<b>Specialty(s):</b>	ASA, AAPM, AANS/CNS, ISIS, NASS, AAPM&R				
<b>CPT Code:</b>	62361				
<b>Sample Size:</b>	6700	<b>Resp N:</b>	37	<b>Response:</b> 0.5 %	
<b>Sample Type:</b>	Panel				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Service Performance Rate</b>		0.00	0.00	<b>0.00</b>	2.00
<b>Survey RVW:</b>		2.30	5.00	<b>5.20</b>	7.00
<b>Pre-Service Evaluation Time:</b>				<b>50.0</b>	
<b>Pre-Service Positioning Time:</b>				<b>15.0</b>	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>15.0</b>	
<b>Intra-Service Time:</b>		20.00	45.00	<b>60.00</b>	60.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
Critical Care time/visit(s):	<b>0.0</b>	99291x 0.0	99292x 0.0		
Other Hospital time/visit(s):	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
Discharge Day Mgmt:	<b>38.0</b>	99238x 1.00	99239x 0.00		
Office time/visit(s):	<b>23.0</b>	99211x 0.0	12x 0.0	13x 1.0	14x 0.0
Prolonged Services:	<b>0.0</b>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

<b>CPT Code:</b>	62361			
		<b>Specialty Recommended</b>		
<b>Physician Work RVU:</b>		<b>6.24</b>		
<b>Pre-Service Evaluation Time:</b>		<b>33.0</b>		
<b>Pre-Service Positioning Time:</b>		<b>10.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>5.0</b>		
<b>Intra-Service Time:</b>		<b>60.00</b>		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
Critical Care time/visit(s):	<b>0.0</b>	99291x 0.0	99292x 0.0	
Other Hospital time/visit(s):	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0
Discharge Day Mgmt:	<b>19.0</b>	99238x 0.5	99239x 0.0	
Office time/visit(s):	<b>23.0</b>	99211x 0.0	12x 0.0	13x 1.0
Prolonged Services:	<b>0.0</b>	99354x 0.0	55x 0.0	56x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61888	010	5.20	Harvard Time

CPT Descriptor Revision or removal of cranial neurostimulator pulse generator or receiver

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
11646	010	10,650	6.21		
<u>CPT Descriptor 1</u> Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 CM					
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
38510	010	10,207	6.69		

CPT Descriptor 2 Biopsy or excision of lymph node(s); open, deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64561	010	7.07	RUC Time

CPT Descriptor Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)

**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: 49.0 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 62361	<u>Key Reference CPT Code:</u> 61888	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	60.00	34.00	
Median Immediate Post-service Time	20.00	18.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	20.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	23.0	16.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	170.00	171.00
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	2.72
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.28	3.00
--	------	------

Urgency of medical decision making	2.28	2.22
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.28	3.11
--------------------------	------	------

Physical effort required	2.83	2.67
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.22	3.00
---	------	------

Outcome depends on the skill and judgment of physician	3.44	3.22
--	------	------

Estimated risk of malpractice suit with poor outcome	3.67	3.50
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.11	3.06
----------------------------------	------	------

Intra-Service intensity/complexity	3.28	3.00
------------------------------------	------	------

Post-Service intensity/complexity	2.50	2.44
-----------------------------------	------	------

**Additional Rationale**

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

This code was originally brought forth to the 3<sup>rd</sup> Five-year review because of potential misvaluation, but was withdrawn because of inadequate survey response numbers. Subsequently, the RUC's Five Year Review Identification Workgroup flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but recent Medicare claims data show it to be moving to an outpatient setting. As an interim measure, the RUC recommended removing the hospital visits, reducing the discharge day from 1.0 to 0.5 and having the code surveyed with a 10 day global period instead of its current 90 day period.

Pre-service time was reduced from 80 minutes to 48 minutes following pre-facilitation. With updated times and survey responses that show it to be more complex than its reference service (61888 – RVUw 5.20) we are recommending a RVUw of 6.24 with an IPUT of 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: 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. This is typically reported with code 62350 - Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy. This code is under review at this RUC meeting.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 62361

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

**Specialty Orthopedic Surgery**      How often? Rarely

**Specialty Other Specialties**      **How often?**

Estimate the number of times this service might be provided nationally in a one-year period? 600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and that the frequency would be approximately twice that of the Medicare population

CPT Code: 62361

Specialty Orthopedic Surgery	Frequency 132	Percentage 22.00 %
Specialty Neurosurgery	Frequency 126	Percentage 21.00 %
Specialty Other Specialties	Frequency 342	Percentage 57.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 296  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare claims data from the RUC database

Specialty Orthopedic Surgery	Frequency 65	Percentage 21.95 %
Specialty Neurosurgery	Frequency 62	Percentage 20.94 %
Specialty Other Specialties	Frequency 169	Percentage 57.09 %

Do many physicians perform this service across the United States? No

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend maintaining the current PLI value for this code.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

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CPT Code:62362      Tracking Number  
 Global Period: 010

Specialty Society Recommended RVU: **6.69**  
 RUC Recommended RVU: **6.05**

CPT Descriptor: Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without reprogramming

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65 year-old man has bilateral leg and pelvic pain (rated 8/10) from prostate cancer with wide metastases. The patient has been placed on oral opiates with some pain relief; however, he has experienced intolerable side effects even with ultra low doses. The patient had undergone placement of a tunneled intrathecal catheter (separately reported) and tolerated a trial of intrathecal opiates. A programmable pump for continuous administration of drug into the intrathecal space is placed subcutaneously and connected to an existing tunneled intrathecal catheter. Postoperative hospital care and office visits are conducted as necessary through the 10 day global period.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 46%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 46%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

Preoperative orders are written including prophylactic antibiotics

The chart is reviewed, the procedure is explained to the patient including risks, benefits, and alternatives to surgery and consent obtained. The patient is marked, positioned typically in the lateral position and prepped. The physician scrubs and drapes in standard fashion. The pump is checked and prepared for implantation. The pump is warmed to 35-45 C. Under sterile conditions, the sterile water is removed from the pump and replaced with the required amount of prescribed fluid.

**Description of Intra-Service Work:**

Physician participates in a time out with the operative team. An abdominal incision is made to create a pocket for the pump in the deep subcutaneous layer beneath the skin. A tunneling rod is advanced subcutaneously from the abdominal pocket around to the spinal incision site. The spinal catheter is attached to the tunneling rod and secured with a ligature. The catheter is pulled through to the subcutaneous pocket. The catheter connection is completed at the spinal site by inserting a metal tubing connector, a strain relief sleeve (optional) and placement of ligatures to secure the connection. At the abdominal site, patency of the catheter is confirmed and the catheter is secured with a non-absorbable ligature to the pump. The pump is secured in the abdominal wall pocket. The skin incision is irrigated and closed and the wound is dressed.

**Description of Post-Service Work:**

The patient is stabilized. External programming of the infusion pump is conducted. Postoperative orders are written and a note placed in the chart. The operative note is dictated. The physician communicates with the patient, family, and other health care professionals. Discharge instructions are reviewed and follow up arrangements completed. Prescriptions are written. Office visits for care of the wound for 10 days after the day of the operation are conducted.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	01/2008					
Presenter(s):	Tripti Kataria, MD, MPH, Eduardo Fraifeld, MD, Alexander Mason, MD, David Bagnall, MD, Charles Mick, MD					
Specialty(s):	ASA, AAPM, AANS/CNS/ ISIS, NASS, AAPM&R					
CPT Code:	62362					
Sample Size:	6700	Resp N:	37	Response: 0.5 %		
Sample Type:	Panel					
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate		0.00	0.00	<b>2.00</b>	17.00	50.00
Survey RVW:		2.65	5.00	<b>5.60</b>	7.45	20.00
Pre-Service Evaluation Time:				<b>50.0</b>		
Pre-Service Positioning Time:				<b>15.0</b>		
Pre-Service Scrub, Dress, Wait Time:				<b>15.0</b>		
Intra-Service Time:		20.00	45.00	<b>60.00</b>	60.00	120.00
Immediate Post Service-Time:	<b><u>20.00</u></b>					
Post Operative Visits	<u>Total Min**</u>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<b><u>0.0</u></b>	99291x <b>0.0</b>	99292x <b>0.0</b>			
Other Hospital time/visit(s):	<b><u>0.0</u></b>	99231x <b>0.0</b>	99232x <b>0.0</b>	99233x <b>0.0</b>		
Discharge Day Mgmt:	<b><u>38.0</u></b>	99238x <b>1.00</b>	99239x <b>0.00</b>			
Office time/visit(s):	<b><u>23.0</u></b>	99211x <b>0.0</b>	12x <b>0.0</b>	13x <b>1.0</b>	14x <b>0.0</b>	15x <b>0.0</b>
Prolonged Services:	<b><u>0.0</u></b>	99354x <b>0.0</b>	55x <b>0.0</b>	56x <b>0.0</b>	57x <b>0.0</b>	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40), 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	62362					
		<u>Specialty Recommended</u>				
Physician Work RVU:		<b>6.69</b>				
Pre-Service Evaluation Time:		<b>33.0</b>				
Pre-Service Positioning Time:		<b>10.0</b>				
Pre-Service Scrub, Dress, Wait Time:		<b>5.0</b>				
Intra-Service Time:		<b>60.00</b>				
Immediate Post Service-Time:	<b><u>20.00</u></b>					
Post Operative Visits	<u>Total Min**</u>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<b><u>0.0</u></b>	99291x <b>0.0</b>	99292x <b>0.0</b>			
Other Hospital time/visit(s):	<b><u>0.0</u></b>	99231x <b>0.0</b>	99232x <b>0.0</b>	99233x <b>0.0</b>		
Discharge Day Mgmt:	<b><u>19.0</u></b>	99238x <b>0.5</b>	99239x <b>0.0</b>			
Office time/visit(s):	<b><u>23.0</u></b>	99211x <b>0.0</b>	12x <b>0.0</b>	13x <b>1.0</b>	14x <b>0.0</b>	15x <b>0.0</b>
Prolonged Services:	<b><u>0.0</u></b>	99354x <b>0.0</b>	55x <b>0.0</b>	56x <b>0.0</b>	57x <b>0.0</b>	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61888	010	5.20	Harvard Time

CPT Descriptor Revision or removal of cranial neurostimulator pulse generator or receiver

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
11646	010	10,650	6.21		
<u>CPT Descriptor 1</u> Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 CM					
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
38510	010	10,207	6.69		

CPT Descriptor 2 Biopsy or excision of lymph node(s); open, deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64561	010	7.07	RUC Time

CPT Descriptor Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)

**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: 51.0 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 62362	<u>Key Reference CPT Code:</u> 61888	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	60.00	34.00	
Median Immediate Post-service Time	20.00	18.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	20.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	23.0	16.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	170.00	171.00
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	2.84	2.74
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.11	3.00
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Urgency of medical decision making	2.11	2.16
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.11	3.11
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Physical effort required	2.74	2.58
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.00	2.95
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Outcome depends on the skill and judgment of physician	3.11	3.05
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Estimated risk of malpractice suit with poor outcome	3.37	3.37
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**INTENSITY/COMPLEXITY MEASURES**

CPT Code      Reference  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	3.11
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Intra-Service intensity/complexity	3.00	2.95
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Post-Service intensity/complexity	2.62	2.47
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**Additional Rationale**

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

This code was originally brought forth to the 3<sup>rd</sup> Five-year review because of potential misvaluation, but was withdrawn because of inadequate survey response numbers. Subsequently, The RUC's Five Year Review Identification Workgroup flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but recent Medicare claims data show it to be moving to an outpatient setting. As an interim measure, the RUC recommended removing the hospital visits, reducing the discharge day from 1.0 to 0.5 and having the code surveyed with a 10 day global period instead of its current 90 day period.

Pre-service time was reduced from 80 minutes to 48 minutes following pre-facilitation. Using IWPUT review, total time and intensity/complexity comparisons with the reference service, we recommend a RVUw of 6.69 with an IWPUT of 0.051.

## **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. This code is typically reported in conjunction with code 62350 - Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy. This code is under review at this RUC meeting.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 62362

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

## Specialty Other Specialties How often?

Estimate the number of times this service might be provided nationally in a one-year period? 11300

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and that the frequency would be approximately twice that of the Medicare population.

CPT Code: 62362

Specialty Neurosurgery	Frequency 4294	Percentage 38.00 %
Specialty Anesthesiology	Frequency 3051	Percentage 27.00 %
Specialty Other Specialties	Frequency 3955	Percentage 35.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,654  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare claims data from the RUC database

Specialty Neurosurgery	Frequency 2149	Percentage 38.00 %
Specialty Anesthesiology	Frequency 1527	Percentage 27.00 %
Specialty Other Specialties	Frequency 1978	Percentage 34.98 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend maintaining the current PLI value for this code.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code: 62365  
Global Period: 010

Tracking Number

Specialty Society Recommended RVU: 4.60  
RUC Recommended RVU: 4.60

CPT Descriptor: Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 65-year old male with bilateral leg and pelvic pain (rated 8/10) from prostate cancer with wide metastases had a subcutaneous implanted pump inserted for continual intrathecal infusion. The patient has had satisfactory pain control; however, he presents with signs and symptoms of infection at the site of the subcutaneous pump pocket necessitating removal of the pump.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 43%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 15%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

Preoperative orders are written including prophylactic antibiotics.

Pre-service includes; a review of hospital admission workup; communicating with the referring physician and other health care professionals; and obtaining informed consent. Surgical site is appropriately identified and marked. Pre-service work also includes pre-operative scrubbing and positioning, prepping, and draping the patient. The patient is placed in the lateral position - axillary roll and pressure point padding is essential to reduce risk of nerve injury

**Description of Intra-Service Work:**

The physician participates in a time out with the operative team.

The skin incision over the pump pocket is reopened, the sutures anchoring the pump are removed, the exit catheter is tied and divided, and the pump device is removed. The pocket is irrigated and the wound closed over external drainage.

**Description of Post-Service Work:**

Post operative orders are written and a report is dictated or written and placed in the medical record.

Post-Service includes: patient stabilization: communicating with the patient, family, and other health care professionals (including written and telephone reports and orders); and discharge day management. All visits for care of the wound for 10 days after the day of the operation are considered part of the post-operative work for the procedure.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	04/2008				
<b>Presenter(s):</b>	Tripti Kataria, MD, MPH, Eduardo Fraifeld, MD, Alexander Mason, MD, Rick Boop, MD, John Wilson, MD, Charles Mick, MD				
<b>Specialty(s):</b>	ASA, AAPM, AANS/CNS, NASS, AAPM&R, ISIS				
<b>CPT Code:</b>	62365				
<b>Sample Size:</b>	188	<b>Resp N:</b>	32	<b>Response:</b> 17.0 %	
<b>Sample Type:</b>	Panel				
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>
<b>Service Performance Rate</b>		0.00	0.00	<b>0.00</b>	2.50
<b>Survey RVW:</b>		1.50	2.94	<b>4.60</b>	5.45
<b>Pre-Service Evaluation Time:</b>				<b>45.00</b>	
<b>Pre-Service Positioning Time:</b>				<b>12.50</b>	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>15.00</b>	
<b>Intra-Service Time:</b>		20.00	30.00	<b>45.00</b>	60.00
<b>Immediate Post Service-Time:</b>	<b>20.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x	<b>0.00</b>	99292x	<b>0.00</b>
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x	<b>0.00</b>	99232x	<b>0.00</b>
<b>Discharge Day Mgmt:</b>	<b>38.00</b>	99238x	<b>1.00</b>	99239x	<b>0.00</b>
<b>Office time/visit(s):</b>	<b>23.00</b>	99211x	<b>0.00</b>	12x	<b>0.00</b>
<b>Prolonged Services:</b>	<b>0.00</b>	99354x	<b>0.00</b>	55x	<b>0.00</b>
				56x	<b>0.00</b>
				57x	<b>0.00</b>

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**Specialty Society Recommended Data**

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process: 2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

<b>CPT Code:</b>	62365	<b>Recommended Physician Work RVU: 4.60</b>		
		<b>Specialty Recommended Pre-Service Time</b>	<b>Specialty Recommended Pre Time Package</b>	<b>Adjustments to Pre-Service Time</b>
<b>Pre-Service Evaluation Time:</b>		33.00	33.00	0.00
<b>Pre-Service Positioning Time:</b>		10.00	1.00	9.00
<b>Pre-Service Scrub, Dress, Wait Time:</b>		5.00	5.00	0.00
<b>Intra-Service Time:</b>		45.00		
<b>Immediate Post Service-Time:</b>	<b>20.00</b>			
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>		
<b>Critical Care time/visit(s):</b>	<b>0.00</b>	99291x	<b>0.00</b>	99292x
<b>Other Hospital time/visit(s):</b>	<b>0.00</b>	99231x	<b>0.00</b>	99232x
<b>Discharge Day Mgmt:</b>	<b>19.00</b>	99238x	<b>0.5</b>	99239x
<b>Office time/visit(s):</b>	<b>23.00</b>	99211x	<b>0.00</b>	12x
<b>Prolonged Services:</b>	<b>0.00</b>	99354x	<b>0.00</b>	55x
				56x
				57x

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36589	010	2.27	RUC Time

CPT Descriptor Removal of tunneled central venous catheter, without subcutaneous port or pump

**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.

Most Recent

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
11646	010	6.21	RUC Time	11,041

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 CM

Most Recent

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
38510	010	6.69	RUC Time	9,700

CPT Descriptor 2 Biopsy or excision of lymph node(s); open, deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61888	010	5.20	Harvard Time

CPT Descriptor Revision or removal of cranial neurostimulator pulse generator or receiver

**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: 37.5 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 62365	<u>Key Reference CPT Code:</u> 36589	<u>Source of Time</u> RUC Time
Median Pre-Service Time	48.00	25.00	
Median Intra-Service Time	45.00	13.00	
Median Immediate Post-service Time	20.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	7.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	23.0	0.00	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>155.00</b>	<b>79.00</b>	
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	3.08	2.58
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.08	2.42
--	------	------

Urgency of medical decision making	3.25	2.42
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.33	2.67
--------------------------	------	------

Physical effort required	3.17	2.75
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.25	2.67
---	------	------

Outcome depends on the skill and judgment of physician	3.42	2.83
--	------	------

Estimated risk of malpractice suit with poor outcome	3.08	2.58
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.08	2.67
----------------------------------	------	------

Intra-Service intensity/complexity	3.08	2.67
------------------------------------	------	------

Post-Service intensity/complexity	3.17	2.58
-----------------------------------	------	------

**Additional Rationale**

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

This code was originally brought forth to the 3<sup>rd</sup> Five-year review because of potential miscalculation, but was withdrawn because of inadequate survey response numbers. Subsequently, the RUC's Five Year Review Identification Workgroup flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but recent Medicare claims data show it to be moving to an outpatient setting. As an interim measure, the RUC recommended removing the hospital visits, reducing the discharge day from 1.0 to 0.5 and having the code surveyed with a 10 day global period instead of its current 90 day period. This code was surveyed for

presentation at the January 2008 RUC meeting but withdrawn due to an inconsistency between the code descriptor and the vignette. The code has been re-surveyed with a revised vignette.

Pre-service time was revised from 72.5 to 48 minutes in keeping with the standard established for other codes in the family. Pre-service times are based on Package 2B with additional time required for positioning for the reasons cited in the pre-service work description.

The median Survey Performance Rate for the code under review is zero. The Service Performance Rate for the Key Reference Service is:

Low	0.00
25 <sup>th</sup> percentile	0.00
Median	0.00
75 <sup>th</sup> percentile	1.00
High	20.00

We are including a supplemental presentation of the survey results. In Attachment 1, you will find our results broken down into three categories: responses from those who indicated that they have not performed the service in the past year, those who indicated that they had performed it in this time frame, and all responses.

While the survey measures show a higher level of intensity/complexity relative to the reference service (code 61888 with 5.20RVUw), we believe, that the median 4.60 RVUw with an IPUT of 0.035 is an appropriate value for this 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. This is typically reported with code 62355 - Removal or previously implanted intrathecal or epidural catheter. This code was reviewed at the January 2008 RUC meeting where the RUC recommended: global - 010; Work RVU = 4.30; Pre-Service time = 48 min (33 min eval, 10 min positioning and 5 min scrub/dress/wait); intra-service = 30 min, post-service time= 20 min. Within the 10 day global, 99238 x 0.5 and 99213 x 1

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 62365

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

**Specialty Neurosurgery**      How often? Sometimes

**Specialty Other Specialties**      **How often?**

Estimate the number of times this service might be provided nationally in a one-year period? 1400

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and the frequency would be about the same as that of the Medicare population

Specialty Neurosurgery Frequency 504 Percentage 36.00 %

Specialty Anesthesiology Frequency 399 Percentage 28.50 %

Specialty Other Specialties Frequency 497 Percentage 35.50 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,433  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data from the RUC database

Specialty Neurosurgery Frequency 516 Percentage 36.00 %

Specialty Anesthesiology Frequency 408 Percentage 28.47 %

Specialty Other Specialties Frequency 509 Percentage 35.51 %

Do many physicians perform this service across the United States? No

## Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend maintaining the current PLI values for this code.

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
February 2008 – Initial RUC Review

**Neurostimulators**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT Codes 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* and 63685 *Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVUs. The enclosed letter from the specialty examines the flaw in the CMS methodology, explaining that the use of a building block from the ground up (or a zero-based building block methodology) results in different work RVUs. The RUC reviewed the original rationale and several cross-specialty comparisons identified in the initial review. The 2010 work RVUs for this family continued to be supported by these reference service comparisons.

**The RUC reaffirms its recommendation of 7.20 for CPT Code 63650 and 63685 for CPT Code 6.05.**

**February 2008 RUC Recommendation**

*63650 Percutaneous implantation of neurostimulator electrode array, epidural*

The specialty societies presented data from 45 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar intra-service time, 60 minutes and 70 minutes respectively. However, the surveyed code requires slightly more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code due to the positioning and needle placement into the thoracic or cervical spine which has significant risk of spinal cord injury. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to a one-half discharge day management service. Therefore, given the comparison to the reference code intensity analysis and IWP/PUT comparisons, the RUC determined that the median work RVU, 7.15 (7.20 for 2010) was appropriate.

**63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**

The specialty societies presented data from 36 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, 61888 *Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had significantly more intra-service time, 60 minutes and 34 minutes respectively. In addition, the surveyed code requires more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to a one-half discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 6.00 (6.05 for 2010) was appropriate.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
63650	Percutaneous implantation of neurostimulator electrode array, epidural	010	7.20 (No Change)
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	010	6.05 (No Change)

August 12, 2010

Barbara Levy, MD  
AMA/Specialty Society RVS Update Committee  
515 N. State Street  
Chicago, IL 60654

Re: Codes with site of service anomalies  
Codes 62263 – Tab 66  
Codes 62350, 62355, 62360, 62361, 62362, 62365 – Tab 67  
Codes 63650, 63685 – Tab 68

Dear Dr. Levy:

We are writing to respond to a request from the RUC to provide supplemental support for several RUC recommendations recently reviewed for site of service anomalies. The above-listed codes underwent review in February and April 2008. CMS has requested that the RUC review these services again and in the proposed rule for the 2011 Physician Fee Schedule, CMS notes that it has *"encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies."*

We have applied a "zero-based building block" to the services referenced above. In this approach we started with a value of zero and built upwards. This is in contrast to the "reverse building block" CMS attempted in which they began with a starting value and pulled work out. That approach was clearly flawed as it resulted in a negative work RVU for several of the services to which it was applied.

In our zero-based approach, we used the accepted standards for pre- and post-service work intensities along with the times that were approved by the RUC in 2008. For intra-service complexity, we used the intensity of the reference service with the time the RUC approved for the code under review. When survey respondents were closely divided on their selected reference service, we provide an additional comparison in our attached spreadsheets. We also include a comparison with a code from the MPC list to further validate our values.

We request that the RUC consider the following elements as it reviews our response:

1. If CMS believes that the best way to ensure that the resources required to provide these services are appropriately valued is via a building block (as appears to be the case given the discussion in the Proposed Rule for the 2011 Medicare Physician Fee Schedule in the July 13, 2010 Federal Register), then CMS must be mindful of the vulnerabilities associated with relying solely on a building block. All components must be accurate and validated. In the reverse building block the starting values were certainly an issue.
2. A building block approach cannot capture the complexities, intricacies and subtleties involved in providing medical care. These would include those elements specified in the RUC survey:
  - a. Mental effort and judgment
  - b. Technical skill
  - c. Physical effort
  - d. Psychological stress

Since a building block cannot account for these factors, the zero-based building block arrives as the same value for several of the services to which we applied it even though there are distinctions between the services. These factors can be acknowledged when the services are reviewed by medically and scientifically trained physicians and other qualified providers.

3. The zero-based approach does serve overall to validate the RUC recommendations for these services. This is illustrated in the attached spreadsheet. However, there will be inconsistencies with any methodology and there are two instances where there is some variation between the RUC recommended value and the value derived from the building block:
  - a. Code 62263 - *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days.* As noted in the February 2008 Summary of Recommendation form, the recommended value for this code was already validated with use of two building block approaches. In the first one, the values of the post-procedures visits were added to the value for code 62264 - *Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day .*

Code	RVU
62264	4.42
99213	0.92
99213	0.92
99212	.045
<b>TOTAL</b>	<b>6.71</b>

The SOR included additional support by adding two halves of code 62282 - *Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)* to the once day code:

Code	RVU
62264	4.42
62282 x .05	1.165
62282 x .05	1.165
<b>TOTAL</b>	<b>6.75</b>

- b. Code 63650 - *Percutaneous implantation of neurostimulator electrode array, epidural.* There was some difficulty in identifying codes that could serve as reference services for these surveys. Subsequent to the RUC reviews of these codes in February and April 2008, new codes have been established and valued that could serve as more appropriate intra-service proxies than the reference services that were then available. This is particularly germane for code 63650. A better proxy would be code 63663 - *Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including*

*fluoroscopy, when performed - which was reviewed by the RUC in April 2009.*  
Using this as the intra-service proxy would yield a RVUw of 6.19

	Intensity	Time	RVU
Pre Service			
Evaluation	.0224	33 min	0.7392
Positioning	.0224	10 min	0.224
Scrub/Dress/Wait	.0081	5 min	0.0405
Intra-Service (63663 as proxy)	.0521	60 min	3.126
Post-Service			
Immediate post-service	.0224	20 min	0.448
Visits within global period		# of visits	
99238	1.28	.05	0.64
99213	0.97	1.00	0.97
<b>TOTAL</b>			<b>6.187</b>

We believe that this approach does validate the RUC recommended values for these services and we strongly urge the RUC to convey that same conclusion to CMS. We further encourage CMS to accept these recommendations and maintain the current values assigned to these codes.

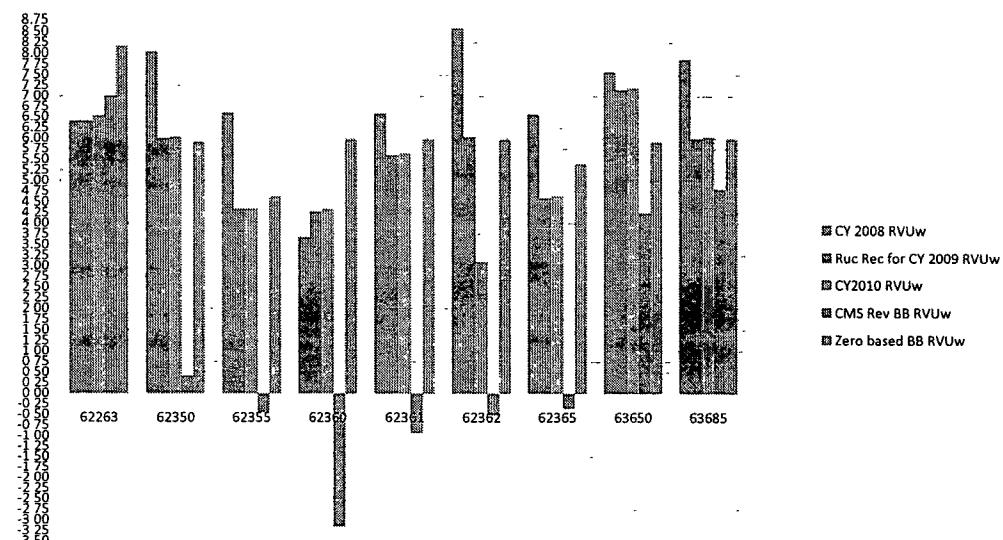
Sincerely,  
American Society of Anesthesiologists  
American Academy of Physical Medicine and Rehabilitation  
North American Spine Society  
American Academy of Pain Medicine  
International Spine Intervention Society  
American Association of Neurological Surgeons  
Congress of Neurological Surgeons

Encl

CY 2008 RVL Ruc Rec for CY 2009 CY2010 RV CMS Rev BB RVUw Zero based BB RVUw

62263	6.41	6.41	6.54	6.99	8.17
62350	8.04	6.00	6.05	0.41	5.92
62355	6.60	4.35	4.35	-0.43	4.63
62360	3.68	4.28	4.35	-3.14	5.98
62361	6.59	5.60	5.65	-0.92	5.98
62362	8.58	6.05	3.10	-0.51	5.98
62365	6.57	4.60	4.65	-0.35	5.41
63650	7.57	7.15	7.20	4.25	5.92
63685	7.87	6.00	6.05	4.80	5.98

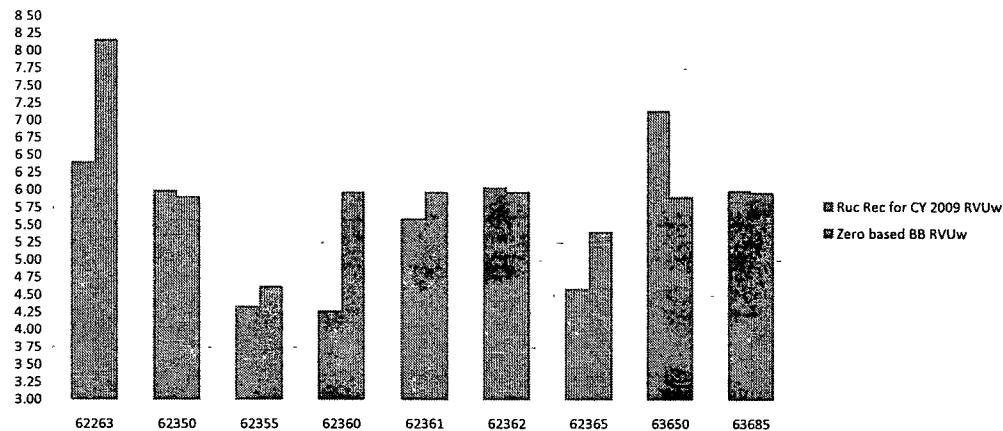
zero based BB with reference service as intraservice proxy



Ruc Rec for CY Zero based BB RVUw

62263	6.41	8.17
62350	6.00	5.92
62355	4.35	4.63
62360	4.28	5.98
62361	5.60	5.98
62362	6.05	5.98
62365	4.60	5.41
63650	7.15	5.92
63685	6.00	5.98

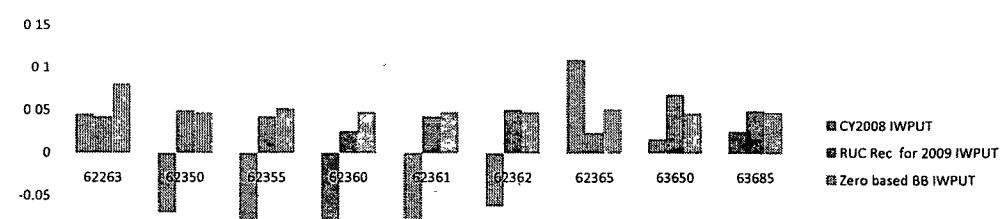
zero based BB with reference service as intraservice proxy



CY2008 IWPI RUC Rec for 2009 Zero based BB IPUT

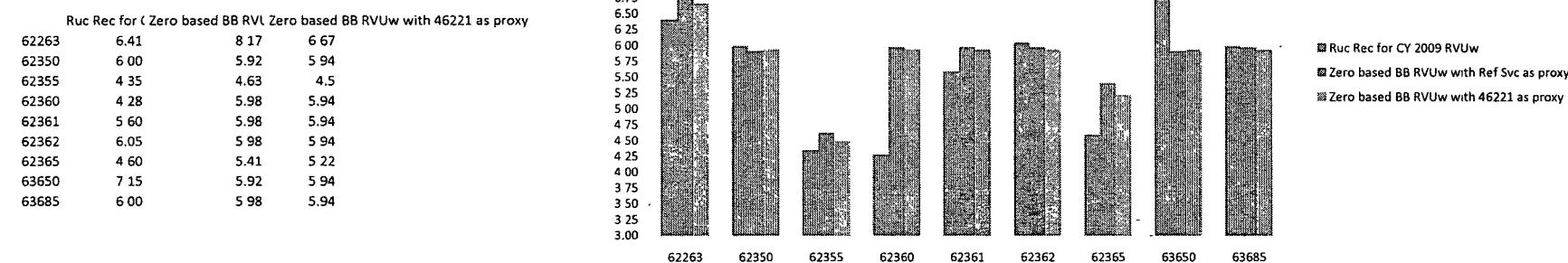
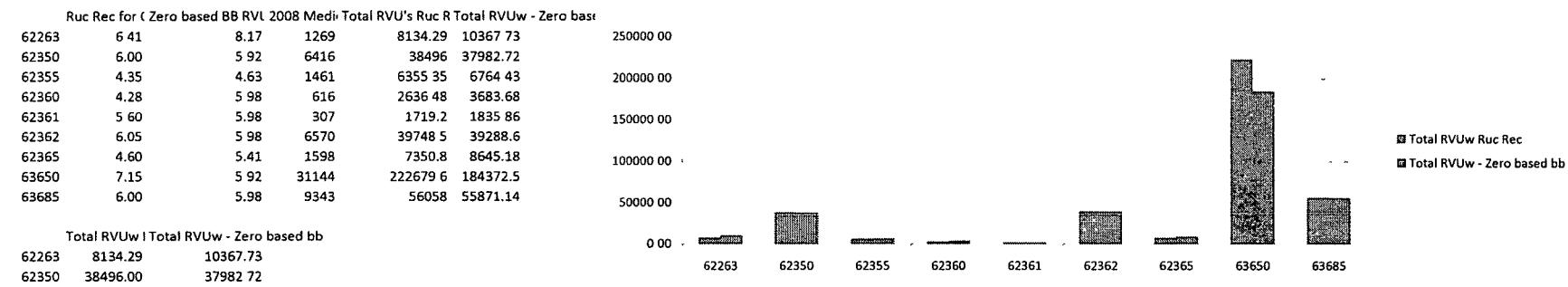
62263	0.046	0.043	0.0813
62350	-0.069	0.05	0.0476
62355	-0.126	0.043	0.0523
62360	-0.136	0.026	0.0486
62361	-0.092	0.043	0.0486
62362	-0.062	0.051	0.0486
62365	0.11	0.024	0.0522
63650	0.017	0.069	0.0476
63685	0.026	0.05	0.0486

zero based BB with reference service as intraservice proxy





#### Aggregate Medicare spending



Pain codes from Table 15 of 2011 Nprm		62263	62350	62355	62360	62361	62362	62365	63650	63655
		Percutaneous lysis of epidural adhesions using solution injection (eg, hyaluronic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesolysis sessions, 1 or more days	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long term medication administration via an external pump or implantable reservoir/infusion pump, without laminectomy	Removal of previously implanted intrathecal or epidural catheter	Implantation or replacement of device for intrathecal or epidural drug infusion, subcutaneous reservoir	Implantation or replacement of device for intrathecal or epidural drug infusion, nonprogrammable pump	Implantation or replacement of device for intrathecal or epidural drug infusion, programmable pump, including preparation of pump, with or without programming	Removal of subcutaneous reservoir of pump previously implanted for intrathecal or epidural infusion	Percutaneous implantation of neurostimulator electrode array, epidural	Insertion or replacement of spinal neurostimulator probe, direct or indirect, without coupling
CY2008 RVU "starting value"		6.41	8.04	6.60	3.68	6.59	8.58	6.57	7.57	7.87
RUC Rec for CY2009		6.41	6.00	4.35	4.28	5.60	6.05	4.60	7.15	6.00
CY2010 Work RVU		6.54	6.05	4.35	4.35	5.65	6.10	4.65	7.20	6.05
CY2011 Rev BB		6.99	0.41	-0.43	-3.14	0.92	-0.51	-0.35	4.25	4.80
Global		10	10	10	10	10	10	10	10	10
	Intensity	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time	RVU (Intensity * Time)	Time
Pre-Service										
Evaluation	0.0224	33	0.7392	33	0.7392	33	0.7392	33	0.7392	33
Positioning	0.0224	10	0.224	10	0.224	10	0.224	10	0.224	10
SDW	0.0081	5	0.0405	5	0.0405	5	0.0405	5	0.0405	5
Intra-Service (using intra-service intensity of ref svc)		45	3.654	60	2.856	30	1.566	60	2.922	45
Reference Service		62364	64561	61569	61888	61888	61888	63659	64561	61888
Post-Service										
Immed Post-Service	0.0224	20	0.448	20	0.448	20	0.448	20	0.448	20
Visits in Global Period										
99291	4.5000	0	0	0	0	0	0	0	0	0
99292	2.2500	0	0	0	0	0	0	0	0	0
99233	2.0000	0	0	0	0	0	0	0	0	0
99232	1.3900	0	0	0	0	0	0	0	0	0
99231	0.7500	0	0	0	0	0	0	0	0	0
99238	1.2800	0.5	0.64	0.5	0.64	0.5	0.64	0.5	0.64	0.5
99239	1.9000	0	0	0	0	0	0	0	0	0
99215	2.1100	0	0	0	0	0	0	0	0	0
99214	1.5000	0	0	0	0	0	0	0	0	0
99213	0.9700	1	0.97	1	0.97	1	0.97	1	0.97	1
99212	0.4800	1	0.48	0	0	0	0	0	0	0
99211	0.1800	0	0	0	0	0	0	0	0	0
TOTAL with zero based BB		8.17	5.92	4.63	5.98	5.98	5.98	5.41	5.92	5.98
2010 IWP/UT		0.0451	0.0498	0.0429	0.0211	0.0431	0.0506	0.0353	0.6900	0.0498
IWP/UT with zero-based BB total		0.0813	0.0476	0.0528	0.04864	0.04864	0.04864	0.05718	0.04764	0.04864
To validate using intra-service proxy when survey responses indicated that many respondents selected a reference service other than the key ref svc										
Pre service total					1.00	1.00	1.00	1.00	1.00	1.00
Post service total					2.06	2.06	2.06	2.06	2.06	2.06
Intra service proxy				code 64561	2.86	code 64561	2.86	code 61888	2.19	
TOTAL					5.92	5.92	5.92	5.25	0.00	3.06

Pain codes from Table 15 of 2011 NPRM		62263	62350	62355	62360	62361	62362	62365	63650	63685
		• Percutaneous trial of epidural or intrathecal infusion device (e.g., catheter, pump, reservoir) for long-term medication administration (includes contrast when administered); multiple admissions (sessions) of more than 24 hours apart	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without tummyectomy	Removal of previously implanted intrathecal or epidural catheter	Implantation or replacement of device for intrathecal or epidural drug infusion, subcutaneous reservoir	Implantation or replacement of device for intrathecal or epidural drug infusion, programmable pump, including preparation of pump, with or without programming	Removal of neurostimulator electrode array, intrathecal or epidural	Percutaneous implantation of neurostimulator electrode array, epidural	Implantation or replacement of spinal neurostimulator electrode array, epidural	Implantation or replacement of spinal neurostimulator electrode array, intrathecal
CY2008 RVU "starting value"		6.41*	8.04	6.60	3.68	6.59	8.58	6.57	7.57	7.87
RUC Rec for CY2009		6.41**	6.00	4.35	4.28	5.60	6.05	4.60	7.15	6.00
CY2010 Work RVU		6.54***	6.05	4.35	4.35	5.65	6.10	4.65	7.20	6.05
CY2011 Rev 8B		6.69****	0.41	-0.43	-3.14	0.92	-0.51	0.35	4.25	4.80
Cross-specialty validation code from MPC list										
Pre service total		1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Post service total		3.51	2.05	2.06	2.06	2.06	2.06	2.06	2.06	2.06
Intra service proxy	Code 46221 IPUT 0479	2.16	2.87	1.64	2.87	2.47	2.87	2.16	2.87	2.87
TOTAL		6.67	5.94	4.50	5.94	5.94	5.94	5.22	5.94	5.94

Tables 15 & 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99234	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75				75	120	43	2	2	2	1	1	1	1	428	0 0145	Pre-RUC Evaluation		
		10.03	2010	1,123	60	10	15	85	90	30	2	2	2					283	0 0530	AAOMS	Post-RUC Evaluation	
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49				49	62	23	3.5		0.5	1	1	1	1	238	0 0886	Pre-RUC Evaluation		
		9.23	2010	1,237	40	15	15	70	60	20	2.0	2.0		0.5	0.5	0.5	0.5	247	0 0648	AAOS	Post-RUC Evaluation	
		7.38	2009		36			36	78	21	5.0		1.5	1	1	1	1	283	0 0192		Pre-RUC Evaluation	
25116	REMOVE WRIST/FOREARM LESION	7.56	2010	1,030	40	10	15	65	60	20	1.0	3.0						0.5	249	0 0307	ASSH, AAOS, ASPS	Post-RUC Evaluation
		7.91	2007		21	25			83	19	4.0		1.5		1	1	1	1	1	1		Pre-RUC Evaluation
27792	TREATMENT OF ANKLE FRACTURE	9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0	1.0	1.0	1.0	1.0	1.0	281	0 0513	AAOS, AOFAS	Post-RUC Evaluation	
		5.64	2009		47			47	67	21	3.5		1.5		1.0	1.0	1.0	1.0	259	0 0056		Pre-RUC Evaluation
28120	PART REMOVAL OF ANKLE/HEEL	8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0	1.0	1.0	1.0	1.0	1.0	280	0 0263	AAOS, APMA	Post-RUC Evaluation	
		7.56	2009		43			43	51	26	5.0		1.5		1.0	1.0	1.0	1.0	268	0 0304		Pre-RUC Evaluation
28122	PARTIAL REMOVAL OF FOOT BONE	7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0	1.0	1.0	1.0	1.0	1.0	264	0 0249	AAOS, APMA	Post-RUC Evaluation	
		11.97	2009		50			50	89	22	4.0		2.5		1.0	1.0	1.0	1.0	313	0 0631		Pre-RUC Evaluation
28725	FUSION OF FOOT BONES	12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0	1.0	1.0	1.0	1.0	339	0 0496	AOFAS, APMA	Post-RUC Evaluation	
		12.21	2009		60			60	120			5.0		1.0		1.0	1.0	1.0	383	0 0331		Pre-RUC Evaluation
28730	FUSION OF FOOT BONES	12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0	1.0	1.0	1.0	1.0	349	0 0471	AAOS	Post-RUC Evaluation	
		3.71	2008		17			25	42	36	16	3.5	0.5		1.0	1.0	1.0	1.0	198	0 0151		Pre-RUC Evaluation
28825	PARTIAL AMPUTATION OF TOE	6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0			1.0	1.0	1.0	1.0	224	0 0099	AAOS	Post-RUC Evaluation
		9.15	2008		29			25	54	75	28	2.5		1.5		1.0	1.0	1.0	265	0 0540		Pre-RUC Evaluation
36821	AV FUSION DIRECT ANY SITE	12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0			1.0	1.0	1.0	1.0	256	0 0823	ACS, SVS, RPA	Post-RUC Evaluation
		10.00	2009		56			56	81	22	2.5		1.0		1.0	1.0	1.0	257	0 0663		Pre-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAPH	15.13	2010	4,873	40	10	20	70	120	30	1.0	2.0	1.0	1.0	1.0	1.0	1.0	340	0 0726	ACS, SVS	Post-RUC Evaluation	
		17.99	2009		55			55	156	37	3.5		1.5		1.0	1.0	1.0	1.0	396.5	0 0671		Pre-RUC Evaluation
42415	EXCISE PARTOID GLAD/LESION	18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0			1.0	1.0	1.0	1.0	342	0 0843	ACS, AAO-HNS	Post-RUC Evaluation
		20.87	2009		57			57	182	22	3.5		3.0		1.0	1.0	1.0	1.0	439.5	0 0687		Pre-RUC Evaluation
42420	EXCISE PARTOID GLAD/LESION	21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0	1.0	1.0	1.0	1.0	432	0 0743	ACS, AAO-HNS	Post-RUC Evaluation	
		7.05	2009		47			47	71	19	1.5		0.5		1.0	1.0	1.0	1.0	209	0 0500		Pre-RUC Evaluation
42440	EXCISE SUBMAXILLARY GLAND	7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0			0.5	193	0 0596	AAO-HNS, ACS	Post-RUC Evaluation			
		9.97	2009		45			45	67.5	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	239.5	0 0711		Pre-RUC Evaluation
49507	PRP I/HERN INIT BLOCK >5 YR	10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	260	0 0680	ACS	Post-RUC Evaluation
		12.36	2009		45			45	90	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	262	0 0799		Pre-RUC Evaluation
49521	REREPAIR ING HERNIA, BLOCKED	12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	280	0 0795	ACS	Post-RUC Evaluation
		7.96	2009		45			45	60	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	232	0 0466		Pre-RUC Evaluation
49587	RPR UNBIL HERN, BLOCK >5 YR	8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	250	0 0459	ACS	Post-RUC Evaluation
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010		45	15	15	75	90	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	292	0 0806	ACS	New Code in 2009
49653	LAP VENT/ABD HERN PROC COMP	16.21	2010		45	15	15	75	120	30	2.0	1.0	1.0		1.0	1.0	1.0	1.0	378	0 0726	ACS	New Code in 2009
49654	LAP INC HERNIA REPAIR	15.03	2010		45	15	15	75	120	30	1.0	1.0	1.0		1.0	1.0	1.0	1.0	362	0 0668	ACS	New Code in 2009
49655	LAP INC HERN REPAIR COMP	18.11	2010	50	15	15	80	150	30	2.0	1.0	1.0		1.0	1.0	1.0	1.0	413	0 0700	ACS	New Code in 2009	
		6.11	2008		47.5			47.5	60	49								156.5	0 0658		Pre-RUC Evaluation	
52341	CYSTO W/URETER STRICTURE TX	5.35	2010	2,105	45	10	15	70	45	20								135	0 0789	AUA	Post-RUC Evaluation	
		6.61	2008		60			60	65	30					1.0			175	0 0590		Pre-RUC Evaluation	
52342	CYSTO W/U P STRICTURE TX	5.85	2010	281	40	10	10	60	60	20								140	0 0700	AUA	Post-RUC Evaluation	
		7.31	2008		60			60	90	30					1.0			200	0 0504		Pre-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	6.55	2010	37	45	10	10	65	60	25								150	0 0780	AUA	Post-RUC Evaluation	
		7.81	2008		60			60	77.5	30					1.0			187.5	0 0650		Pre-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.05	2010	2,447	40	10	10	60	45	20								125	0 1200	AUA	Post-RUC Evaluation	
		8.31	2008		50			50	90	30					1.0			190	0 0640		Pre-RUC Evaluation	
52345	CYSTO/URETERO W/U P STRICTURE	7.55	2010	475	45	10	15	70	45	20								135	0 1277	AUA	Post-RUC Evaluation	
		9.34	2008		45			45	120	49								214	0 0603		Pre-RUC Evaluation	
52346	CYSTOURETERO W/RENAL STRICT	8.58	2010	144	40	10	10	60	60	20								140	0 1155	AUA	Post-RUC Evaluation	
		10.06	2008		90			90	60	30					1.0			261	0 0727		Pre-RUC Evaluation	
52400	CYSTOURETERO W/CONGEN REPR	8.69	2010	635	72.5	10	15	97.5	40	25	1.0	1.0	1.0		0.5	197.5	0 1260	AUA	Post-RUC Evaluation			
		9.39	2008		40			40	45	35					3.0			1.0	247	0 0613		Pre-RUC Evaluation
52500	REVISION OF BLADDER NECK	8.14	2010	5,348	45	10	15	70	45	27.5					3.0			0.5	230.5	0 0582	AUA	Post-RUC Evaluation
		6.89	2008		50			50	39	17	2.0	2.0						10	216	0 0509		Pre-RUC Evaluation
52640	RELIEVE BLAD CONTRA	4.79	2010	2,217	40	10	10	60	30	20					0.5	161	0 0514	AUA	Post-RUC Evaluation			

Tables 15 & 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	96121	96122	96123	96124	96125	96126	96127	96128	96129	Total Time	IWPUT	Specialty Societies	Review
			15.21	2009	75			75	126	24		3.0	3.0		1.0	1.0	1.0	1.0	1.0	1.0	392	0.0546	Pre-RUC Evaluation
53445	INSERT URO/VES NCK SPHINCTER	15.39	2010	1,949	50	15	20	85	90	25	1.0	3.0		1.0	1.0	1.0	1.0	1.0	1.0	418	0.0572	AUA	Post-RUC Evaluation
54410	REMOVE/REPLACE PENIS PROSTH	15.18	2010	1,328	40	10	15	65	120	30	1.0	3.0		1.0	1.0	1.0	1.0	1.0	1.0	369	0.0635	Pre-RUC Evaluation	Post-RUC Evaluation
54530	REMOVAL OF TESTIS	9.31	2008	58	10	15	82.5	60	30	2.0	1.0	2.5	0.5	1.0	238.5	0.0673	Pre-RUC Evaluation	Post-RUC Evaluation					
57287	REVISE/REMOVE SLING REPAIR	11.49	2008	45	10	10	45	70	30	1.0	2.0	2.0	1.0	283	0.0656	AAS	Pre-RUC Evaluation	Post-RUC Evaluation					
61885	INSRT/REDO NEUROSTIM 1 ARRAY	7.37	2009	50	3	15	50	60	25	1.0	4.0	1.0	0	1.0	326	-0.027	Pre-RUC Evaluation	Post-RUC Evaluation					
62263	EPIDURAL LYSIS MULT SESSIONS	6.44	2010	4,358	93	3	45	30	20	2.0	2.0	2.0	1.0	200	0.0435	AAPM, AANS/CNS, NASS, ASA	Pre-RUC Evaluation	Post-RUC Evaluation					
62350	IMPLANT SPINAL CANAL CATH	6.54	2010	1,269	33	10	5	48	45	20	1.0	2.0		0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation	Pre-RUC Evaluation				
62355	REMOVE SPINAL CANAL CATHETER	6.60	2008	60				60	40	130	3.0	1.0	1.0	2.0	1.0	446	-0.1284	AAPM, AANS/CNS, ASA, ISIS, NASS	Pre-RUC Evaluation	Post-RUC Evaluation			
62360	INSERT SPINE INFUSION DEVICE	4.35	2010	1,461	33	10	5	48	30	20	1.0	1.0		0.5	140	0.0429	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation	Pre-RUC Evaluation				
62361	IMPLANT SPINE INFUSION PUMP	3.68	2008	60				60	60	130	4.0	1.0		2.0	1.0	450	-0.1385	AAPM, AANS/CNS, ASA, ISIS, NASS	Pre-RUC Evaluation	Post-RUC Evaluation			
62362	IMPLANT SPINE INFUSION PUMP	6.59	2010	307	33	10	5	48	60	20	1.0	1.0		2.0	1.0	482	-0.0938	AAPM, AANS/CNS, ASA, ISIS, NASS	Pre-RUC Evaluation	Post-RUC Evaluation			
62365	REMOVE SPINE INFUSION DEVICE	6.10	2010	6,570	33	10	5	48	60	20	1.0	1.0		2.0	1.0	446	-0.1123	AAPM, AANS/CNS, ASA, ISIS, NASS	Pre-RUC Evaluation	Post-RUC Evaluation			
62366	REPAIR SPINE INFUSION DEVICE	4.65	2010	1,598	33	10	5	48	45	20	1.0	1.0		0.5	155	0.0353	AAPS/CNS	Post-RUC Evaluation	Pre-RUC Evaluation				
63650	IMPLANT NEUROELECTRODES	7.20	2010	31,144	33	10	5	48	60	20	1.0	1.0		0.5	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation	Pre-RUC Evaluation				
63685	INSRT/REDO SPINE N GENERATOR	7.87	2008	53				53	62	18	2.5	0.5		1.0	2.5	1.0	267	0.0245	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation	Pre-RUC Evaluation		
64708	REVISE ARM/LEG NERVE	6.05	2010	9,343	33	10	5	48	76	18	2.5	0.5		1.0	228	0.0301	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation	Pre-RUC Evaluation				
64831	REPAIR OF DIGIT NERVE	6.36	2010	3,069	35	10	10	55	60	15	3.0	1.0		0.5	220	0.0314	AAOS, ASPS	Post-RUC Evaluation	Pre-RUC Evaluation				
64831	REPAIR OF DIGIT NERVE	10.23	2008	50				50	74	21	2.5	1.0		1.0	260.5	0.0612	AAOS, ASPS, ASSH	Post-RUC Evaluation	Pre-RUC Evaluation				
64831	REPAIR OF EYE WOUND	9.16	2010	972	40	10	15	65	60	15	2.0	2.0		0.5	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation	Pre-RUC Evaluation				
65285	REPAIR OF EYE WOUND	14.43	2009	52				52	79	32	5.5	0.5											

Codes to be reviewed on the Fourth Five-Year Review Agenda (52640 and 52787) and recent May 2010 Submission (61885)

23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values.

\*2010 Post- RUC Review work RVWs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10.

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11179 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC’s recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomalies concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs)	2 visits (0.36 RVUs).	2 visits (0.96 RVUs)	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	-0.44 RVUs	0.38 RVUs ...	-0.76 RVUs	-1.39 RVUs	-0.64 RVUs	-0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39)$

$$- 0.64 - 0.36 = 8.08$$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs (“starting value”)	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insrt/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs (“starting value”)	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insrt/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC’s most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IWP/PUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IWP/PUT is counterintuitive to the IWP/PUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2008

### **Neurostimulators**

CPT codes describing neurostimulators (63650, 63660, 63685 and 63688) were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomalies utilizing information from the current physician time data and the Medicare claims data. The physician time data for these codes currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that these services are typically performed in an outpatient setting. CMS agreed with the RUC that these services should be evaluated.

#### *63650 Percutaneous implantation of neurostimulator electrode array, epidural*

The specialty societies presented data from 45 pain medicine physicians, neursurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, 64561 *Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)* (Work RVU=7.07). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar intra-service time, 60 minutes and 70 minutes respectively. However, the surveyed code requires slightly more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code due to the positioning and needle placement into the thoracic or cervical spine which has significant risk of spinal cord injury. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the reference code intensity analysis and IPUT comparisons, the RUC determined that the median work RVU, 7.15 was appropriate. **The RUC recommends 7.15 RVUs for 63650.**

#### *63660 Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)*

The specialty societies recommend that this code be referred to the CPT Editorial Panel to more clearly define the service as the current CPT descriptor makes this code difficult to survey and value, i.e. remove or revise. **The RUC recommends that 63660 be referred to the CPT Editorial Panel.**

*63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling*

The specialty societies presented data from 36 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, *61888 Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had significantly more intra-service time, 60 minutes and 34 minutes respectively. In addition, the surveyed code requires more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 2.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 6.00 was appropriate. **The RUC recommends 6.00 RVUs for 63685.**

*63688 Revision or removal of implanted spinal neurostimulator pulse generator or receiver*

The specialty societies presented data from 35 pain medicine physicians, neurosurgeons, anesthesiologists, spine surgeons and physical medicine and rehabilitation physicians. The RUC compared the surveyed code to the reference code, *61888 Revision or removal of cranial neurostimulator pulse generator or receiver* (Work RVU=5.20). The RUC reviewed the survey data presented by the specialty societies and determined that the surveyed code in comparison to the reference code had similar total service time, 165 minutes and 171 minutes respectively. In addition, the surveyed code and the reference code require similar technical skill, physical effort and overall intensity to perform. In addition, the RUC noted that the survey data supported that this service is now more frequently being performed in the outpatient setting as the 1.5-99231 hospital visits have been removed and the full discharge day management service has been reduced to half a discharge day management service. Therefore, given the comparison to the reference code, the RUC determined that the median work RVU, 5.25 was appropriate. **The RUC recommends 5.25 RVUs for 63688.**

Practice Expense:

The practice expense inputs, specifically for the discharge day management and the number and level of office visits for 63650, 63685 and 63688 are recommended to be modified to reflect the current survey data.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommenda- tion
63650		Percutaneous implantation of neurostimulator electrode array, epidural	010	7.15
63660		Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)	010	Referred to the CPT Editorial Panel
63685		Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	010	6.00
63688		Revision or removal of implanted spinal neurostimulator pulse generator or receiver	010	5.25

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:63650      Tracking Number  
Global Period: 010

Specialty Society Recommended RVU: 7.15  
RUC Recommended RVU: 7.15

CPT Descriptor: Percutaneous implantation of neurostimulator electrode array, epidural

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 49 year-old man with intractable, neuropathic back and leg pain following prior lumbar surgery has failed medical management of his pain with opiates and other adjuvant therapies. A percutaneous thoracic epidural neurostimulator array is placed to determine whether dorsal column stimulation would successfully control his leg pain. The subsequent implantation of and connection to an implantable pulse generator or inductive receiver is separately reportable. Postoperative hospital care and office visits are conducted as necessary through the 10 day global period.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 49%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 22%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

Preoperative orders are written including prophylactic antibiotics.

Pre-Service includes: communicating with the referring physician and other health care professionals; and obtaining informed consent. Operative site is appropriately identified and marked. Pre-service work also includes pre-operative scrubbing and positioning (usually in the prone position), prepping, and draping the patient.

**Description of Intra-Service Work:**

The physician participates in a time out with the operative team.

The interlaminar target site in the upper lumbar spine is located using fluoroscopy. The soft tissue structures over the target are anesthetized to the level of the lamina. A Touhy needle is advanced into the epidural space using a loss of resistance technique. Epidural location is advanced into the epidural space using a loss of resistance technique. Epidural location is confirmed with a percutaneous probe. A percutaneous electrode array is guided into the epidural space through the needle and advanced toward the mid thoracic spine. The exposed end of the electrode array is attached to an external stimulator unit. A technician tests various electrode combinations and the lead is physically relocated until the patient indicates that the dermatomal areas of his typical pain have been covered with the paresthesias generated by the stimulator. Lead impedances are checked. The external unit is detached, the needle and stylet removed, and the lead is anchored to the skin. A final fluoroscopic image is obtained to document final placement.

**Description of Post-Service Work:**

Post operative orders are written and an operative report dictated.

Post-Service includes; patient stabilization; training patient in the use of the spinal cord stimulator controls, communicating with the patient, family , and other health care professionals (including written and telephone reports and orders); and discharge day management. Additionally, post-discharge office visits for care of the wound for 10 days after the day of the procedure are considered part of the post-operative work for this procedure.

**SURVEY DATA**

<b>RUC Meeting Date (mm/yyyy)</b>	01/2008					
<b>Presenter(s):</b>	Tripti Kataria, MD, MPH, Eduardo Fraifeld, MD, Alexander Mason, MD, David Bagnall, MD, Charles Mick, MD					
<b>Specialty(s):</b>	ASA, AAPM, AANS/CNS, ISIS, NASS, AAPM&R					
<b>CPT Code:</b>	63650					
<b>Sample Size:</b>	6700	<b>Resp N:</b>	45	<b>Response:</b> 0.6 %		
<b>Sample Type:</b>	Panel					
		<b>Low</b>	<b>25<sup>th</sup> pctl</b>	<b>Median*</b>	<b>75<sup>th</sup> pctl</b>	
<b>Service Performance Rate</b>		0.00	0.00	<b>9.00</b>	21.00	
<b>Survey RVW:</b>		1.78	5.20	<b>7.15</b>	8.80	
<b>Pre-Service Evaluation Time:</b>				<b>50.0</b>		
<b>Pre-Service Positioning Time:</b>				<b>15.0</b>		
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>12.0</b>		
<b>Intra-Service Time:</b>		30.00	50.00	<b>60.00</b>	90.00	
<b>Immediate Post Service-Time:</b>	<b>20.00</b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<b>0.0</b>	99291x	<b>0.0</b>	99292x	<b>0.0</b>	
Other Hospital time/visit(s):	<b>0.0</b>	99231x	<b>0.0</b>	99232x	<b>0.0</b>	
Discharge Day Mgmt:	<b>19.0</b>	99238x	<b>0.50</b>	99239x	<b>0.00</b>	
Office time/visit(s):	<b>23.0</b>	99211x	<b>0.0</b>	12x	<b>0.0</b>	
			13x	<b>1.0</b>	14x	<b>0.0</b>
				15x	<b>0.0</b>	
Prolonged Services:	<b>0.0</b>	99354x	<b>0.0</b>	55x	<b>0.0</b>	
			56x	<b>0.0</b>	57x	<b>0.0</b>

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238 (38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

<b>CPT Code:</b>	63650					
		<b>Specialty Recommended</b>				
<b>Physician Work RVU:</b>	<b>7.15</b>					
<b>Pre-Service Evaluation Time:</b>	<b>33.0</b>					
<b>Pre-Service Positioning Time:</b>	<b>10.0</b>					
<b>Pre-Service Scrub, Dress, Wait Time:</b>	<b>5.0</b>					
<b>Intra-Service Time:</b>	<b>60.00</b>					
<b>Immediate Post Service-Time:</b>	<b>20.00</b>					
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>				
Critical Care time/visit(s):	<b>0.0</b>	99291x	<b>0.0</b>	99292x	<b>0.0</b>	
Other Hospital time/visit(s):	<b>0.0</b>	99231x	<b>0.0</b>	99232x	<b>0.0</b>	
Discharge Day Mgmt:	<b>19.0</b>	99238x	<b>0.5</b>	99239x	<b>0.0</b>	
Office time/visit(s):	<b>23.0</b>	99211x	<b>0.0</b>	12x	<b>0.0</b>	
			13x	<b>1.0</b>	14x	<b>0.0</b>
				15x	<b>0.0</b>	
Prolonged Services:	<b>0.0</b>	99354x	<b>0.0</b>	55x	<b>0.0</b>	
			56x	<b>0.0</b>	57x	<b>0.0</b>

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64561	010	7.07	RUC Time

CPT Descriptor Percutaneous implantation of neurostimulator electrodes; sacral nerve (transforaminal placement)

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
11646	010	10,650	6.21		

CPT Descriptor 1 Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
38510	010	10,207	6.69		

CPT Descriptor 2 Biopsy or excision of lymph node(s); open, deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 44.0 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 63650	<u>Key Reference CPT Code:</u> 64561	<u>Source of Time</u> RUC Time
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	60.00	70.00	
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	19.0	19.00	
Median Office Visit Time	23.0	40.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	170.00	204.00
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	3.26
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.45	3.11
--	------	------

Urgency of medical decision making	2.55	2.53
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	3.90	3.63
--------------------------	------	------

Physical effort required	3.20	3.00
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.50	3.37
---	------	------

Outcome depends on the skill and judgment of physician	4.10	3.84
--	------	------

Estimated risk of malpractice suit with poor outcome	3.95	3.79
--	------	------

**INTENSITY/COMPLEXITY MEASURES****CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.53	3.37
----------------------------------	------	------

Intra-Service intensity/complexity	3.79	3.63
------------------------------------	------	------

Post-Service intensity/complexity	3.57	3.05
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**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.*

This code was originally brought forth to the 3<sup>rd</sup> Five-year review because of potential miscalculation, but was withdrawn because of inadequate survey response numbers. Subsequently, the RUC's Five Year Review Identification Workgroup

flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but recent Medicare claims data show it to be moving to an outpatient setting. As an interim measure, the RUC recommended removing the hospital visits, reducing the discharge day from 1.0 to 0.5 and having the code surveyed with a 10 day global period instead of its current 90 day period.

Pre-service time was reduced from 77 minutes to 48 minutes following pre-facilitation. Our survey responses support removal of hospital visits and reduction of the discharge. Positioning and needle placement into the thoracic or cervical spine with significant risk of spinal cord injury add to the complexity and risk associated with this service compared with the reference service. In addition, a wake-up test of lead positioning may be performed while the patient is still positioned. Although total time is somewhat less than the reference service, intensity analysis and IWP/PUT comparisons support a recommendation of the median survey response of 7.15 RVUw with an IWP/PUT of 0.069.

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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: 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. This would be reported in conjunction with code 63685 - Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling. This code is under review at this RUC meeting.
- 

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 63650

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology	How often? Commonly
--------------------------	---------------------

Specialty Pain Mgmt/Interventional Pain Mgmt	How often? Commonly
--	---------------------

Specialty Other Specialties	How often?
-----------------------------	------------

Estimate the number of times this service might be provided nationally in a one-year period? 30000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and that the frequency would be approximately twice that of the Medicare population

CPT Code: 63650

Specialty Anesthesiology	Frequency 13500	Percentage 45.00 %
Specialty Pain Mgmt/Interventional Pain Mgmt	Frequency 12900	Percentage 43.00 %
Specialty Other Specialties	Frequency 3600	Percentage 12.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 14,724 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare claims data from the RUC database

Specialty Anesthesiology	Frequency 6626	Percentage 45.00 %
Specialty Pain Mgmt/Interventional Pain Mgmt	Frequency 6331	Percentage 42.99 %
Specialty Other Specialties	Frequency 1767	Percentage 12.00 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend maintaining the current PLI values for this code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS  
SUMMARY OF RECOMMENDATION**

CPT Code:63685      Tracking Number  
Global Period: 010

Specialty Society Recommended RVU: **6.00**  
RUC Recommended RVU: **6.00**

CPT Descriptor: Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

**CLINICAL DESCRIPTION OF SERVICE:**

Vignette Used in Survey: A 49 year-old man with intractable back and leg pain has failed conservative treatment for management of his pain and underwent a successful trial of a percutaneously placed dorsal column stimulator electrode array. A subcutaneous neurostimulator pulse generator is placed and connected to the distal portion of the electrode array that is tunneled to the subcutaneous pocket for attachment to the generator. Postoperative hospital care and office visits are conducted as necessary through the 10 day global period.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 50%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 22%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: On the morning of surgery the physician meets the patient and his family in the pre-operative holding area. The patient's history and physical is reviewed and updated. The patient and his family are counseled as to risks, benefits, complications and alternatives to surgery. Their questions are answered and informed consent obtained. The site of surgery is marked. It is checked to be sure that his pre-operative labs are in order and that he received his peri-operative antibiotics. The patient is brought into the operating room and properly positioned. The skin incision is marked, prepped and infiltrated with lidocaine.

Description of Intra-Service Work: Following draping, the time out procedure is performed. The skin incision is then made and electrocautery used to obtain hemostasis. A subcutaneous pocket is made to house the stimulator or if the procedure is for replacement of a generator the old generator is dissected out of the pocket. The electrodes are tunneled to the pocket and out onto the skin or disconnected from the pulse generator in the case of replacement. The neurostimulator pulse generator is then unpackaged, soaked in antibiotic solution and attached to the lead terminals in standard fashion. The generator is then placed in the subcutaneous pocket. The lead impedances are tested to verify proper connection and the device is programmed to begin stimulation. The wound is checked a final time for hemostasis and then irrigated copiously with antibiotic irrigation. The wound is closed in layers. A sterile dressing is applied. The patient is then transported to the recovery room in stable condition.

Description of Post-Service Work: Post-operative orders are written. The operative report is dictated. The patient's family is counseled as to the surgery. The patient is visited in the recovery room and the wound checked. A letter is dictated to his referring physician. Discharge instructions and prescriptions for pain medications or antibiotics are given to the patient. Post-discharge office visits for 10 days after the day of the operation are considered part of the post-operative work for this procedure.

**SURVEY DATA**

RUC Meeting Date (mm/yyyy)	01/2008				
Presenter(s):	Tripti Kataria, MD, MPH, Eduardo Fraifeld, MD, Alexander Mason, MD, David Bagnall, MD, Charles Mick, MC				
Specialty(s):	ASA, AAPM, AANS/CNS, ISIS, NASS, AAPM&R				
CPT Code:	63685				
Sample Size:	6700	Resp N:	36	Response: 0.5 %	
Sample Type:	Panel				
		Low	25 <sup>th</sup> pctl	Median*	75 <sup>th</sup> pctl
Service Performance Rate		0.00	0.00	7.00	20.00
Survey RVW:		2.27	5.19	6.00	8.50
Pre-Service Evaluation Time:				45.0	
Pre-Service Positioning Time:				15.0	
Pre-Service Scrub, Dress, Wait Time:				11.0	
Intra-Service Time:		20.00	35.00	60.00	61.00
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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:	19.0	99238x 0.50	99239x 0.00		
Office time/visit(s):	23.0	99211x 0.0	12x 0.0	13x 1.0	14x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	63685				
		<u>Specialty Recommended</u>			
Physician Work RVU:		6.00			
Pre-Service Evaluation Time:		33.0			
Pre-Service Positioning Time:		10.0			
Pre-Service Scrub, Dress, Wait Time:		5.0			
Intra-Service Time:		60.00			
Immediate Post Service-Time:	20.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
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:	19.0	99238x 0.5	99239x 0.0		
Office time/visit(s):	23.0	99211x 0.0	12x 0.0	13x 1.0	14x 0.0
Prolonged Services:	0.0	99354x 0.0	55x 0.0	56x 0.0	57x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
61888	010	5.20	Harvard Time

CPT Descriptor Revision or removal of cranial neurostimulator pulse generator or receiver

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
11646	010	10,650	6.21		
<u>CPT Descriptor 1</u> Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm					
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
38510	010	10,207	6.69		

CPT Descriptor 2 Biopsy or excision of lymph node(s); open , deep cervical node(s)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
<u>CPT Descriptor</u>			

**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 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 63685	<u>Key Reference CPT Code:</u> 61888	<u>Source of Time</u> Harvard Time
Median Pre-Service Time	48.00	45.00	
Median Intra-Service Time	60.00	34.00	
Median Immediate Post-service Time	20.00	18.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	20.00	
Median Discharge Day Management Time	19.0	38.00	
Median Office Visit Time	23.0	16.00	
Prolonged Services Time	0.0	0.00	

Median Total Time	170.00	171.00
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	2.67	2.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	2.53
--	------	------

Urgency of medical decision making	2.13	2.07
------------------------------------	------	------

**Technical Skill/Physical Effort (Mean)**

Technical skill required	2.87	2.80
--------------------------	------	------

Physical effort required	2.60	2.53
--------------------------	------	------

**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	2.67	2.73
---	------	------

Outcome depends on the skill and judgment of physician	2.93	2.93
--	------	------

Estimated risk of malpractice suit with poor outcome	3.00	3.07
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

CPT Code      Reference  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	2.62	2.46
----------------------------------	------	------

Intra-Service intensity/complexity	2.92	2.69
------------------------------------	------	------

Post-Service intensity/complexity	2.38	2.23
-----------------------------------	------	------

**Additional Rationale**

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

This code was originally brought forth to the 3<sup>rd</sup> Five-year review because of potential misvaluation, but was withdrawn because of inadequate survey response numbers. Subsequently, the RUC's Five Year Review Identification Workgroup flagged this code as having a site of service anomaly. When originally proposed and valued, the service was provided predominately in an inpatient setting but recent Medicare claims data show it to be moving to an outpatient setting. As an interim measure, the RUC recommended removing the hospital visits, reducing the discharge day from 1.0 to 0.5 and having the code surveyed with a 10 day global period instead of its current 90 day period.

Our recommendations are consistent with a site of service change. Using total time (particularly nearly double the intraservice time) and intensity comparisons with the reference service along with an IPUT review, we recommend the median survey result of 6.00 RVUw with an IPUT of 0.050.

## **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. This is typically reported with 63650 - Percutaneous implantation of nuerostimulator electrode array, epidural. This code is under review at this RUC meeting.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 63685

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

**Specialty Anesthesiology**      How often? Sometimes

Specialty Other Specialties How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10900

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We estimate that the Medicare percentages would apply to the general population and that the frequency would be approximately twice that of the Medicare population

Specialty Anesthesiology

Frequency 3270

Percentage 30.00 %

Specialty Neurosurgery                    Frequency 3052                    Percentage 28.00 %

Specialty Other Specialties               Frequency 4578                    Percentage 42.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,452  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2006 Medicare claims data from the RUC database

Specialty Anesthesiology                 Frequency 1636                    Percentage 30.00 %

Specialty Neurosurgery                 Frequency 1526                    Percentage 27.98 %

Specialty Other Specialties               Frequency 2290                    Percentage 42.00 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. We recommend maintaining the current PLI value for this code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

Code	62263	
Descriptor	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic	
	2007	RUC Approve
Global	90	10
IWPUT	0.046	0.043
RVUw	6.41	6.41
Pre-service eval & positioning time	40.00	43.00
Pre-service scrub, dress, wait time		5.00
Intra-service time	30.00	45.00
Immediate post time	20.00	20.00
Subsequent visits	99231 x 2	
	99238 x 1	99238 x 0.5
	99212 x 2	99212 x 1
		99213 x 2

TAB I

Code	63650		To CPT 63660		63685		63688	
Descriptor	Percutaneous implantation of neurostimulator electrode array, epidural		Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddles(s)		Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling		Revision or removal of implanted spinal neurostimulator pulse generator or receiver	
	2007	RUC Approve	2007	Recommend	2007	RUC Approve	2007	RUC Approve
Global	90	10	90	10	90	10	90	10
IWPUT	0.017	0.069	0.023	0.051	0.026	0.050	0.013	0.041
RVUw	7.57	7.15	6.87	6.87	7.87	6.00	6.10	5.25
Pre-service eval & positioning time	31.00	43.00	24.00	24.00	28.00	43.00	23.00	43.00
Pre-service scrub, dress, wait time		5.00	25.00	25.00	25.00	5.00	25.00	5.00
Intra-service time	25.00	5.00	64.00	64.00	62.00	60.00	59.00	55.00
Immediate post time	74.00	60.00	18.00	18.00	18.00	20.00	17.00	20.00
Subsequent visits	19.00	20.00	99231 x 1.5	99231 x 1.5	99231 x 2.5		99231 x 1.5	
	99238 x 1	99238 x 0.5	99238 x 1	99238 x 0.5	99238 x 1	99238 x 0.5	99238 x 1	99238 x 0.5
	99213 x 2	99213 x 1	99213 x 2	99213 x 2	99213 x 2	99213 x 1	99213 x 2	99213 x 1
			99212 x 4					

TAB H

Code	62350		62355		Deferred to Apr 62360		62361		62362		RESURVEY 62365	
Descriptor	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy		Removal of previously implanted intrathecal or epidural catheter		Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir		Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump		Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without reprogramming		Removal of subcutaneous reservoir or pump previously implanted for intrathecal or epidural infusion	
	2007	RUC Approve	2007	RUC Approve	2007	Recommend	2007	RUC Approve	2007	RUC Approve	2007	Recommend
Global	90	10	90	10	90	10	90	10	90	10	90	10
IWPUT	(0.069)	0.050	(0.126)	0.043	(0.136)	0.026	(0.092)	0.043	(0.062)	0.051	(0.110)	0.024
RVUw	8.04	6.00	6.60	4.30	13.68	5.24	6.59	5.60	8.58	6.05	6.57	5.10
Pre-service eval & positioning time	70.00	43.00	60.00	43.00	60.00	43.00	60.00	43.00	75.00	43.00	60.00	43.00
Pre-service scrub, dress, wait time		5.00		5.00		5.00		5.00		5.00		5.00
Intra-service time	60.00	60.00	40.00	30.00	55.00	60.00	60.00	60.00	90.00	60.00	45.00	60.00
Immediate post time	125.00	20.00	130.00	20.00	123.00	20.00	130.00	20.00	150.00	20.00	125.00	20.00
Subsequent visits	99233 x 2		99233 x 2		99233 x 2		99233 x 2		99233 x 3		99233 x 2	
	99231 x 1		99231 x 1		99238 x 1	99238 x 1	99231 x 1		99238 x 1	99238 x 0.5	99231 x 1	
	99238 x 1	99238 x 0.5	99238 x 1	99238 x 0.5	99212 x 4	99213 x 1	99238 x 1	99238 x 0.5	99212 x 4	99213 x 1	99238 x 1	
	99212 x 4	99213 x 1	99212 x 3	99213 x 1			99212 x 4	99213 x 1			99212 x 3	99213 x 1

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
April 2008 – Initial RUC Review

**Neuroplasty-Leg or Arm**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT code 64708, *Neuroplasty, major peripheral nerve, arm or leg; other than specified*, and 64712, *Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 6.36. The enclosed letter from the specialty articulates that despite a survey that indicated much higher work relativity, the specialty recommended the current valuation as there was no compelling evidence to increase the value. The specialty agreed that the reference services used by the RUC to validate the current value were appropriate: 19298, *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance*, (work RVU = 6.00, intra-service time = 60 minutes) and 30520, *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (work RVU = 6.85, intra-service time = 60 minutes). The specialty also explained that the Harvard study measured post-operative time and did not articulate visits. The RUC agreed that the previous valuation was appropriate.

The RUC also reviewed a table of codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IWPPUT. This review using magnitude estimation comparison of work RVUs further supports the current work RVU for 64708.

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPPUT	TOT Time	PRE			INTR	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2009	21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	090	5.42	0.043	174	33	8	15	45	15	0.5	1	1
2009	28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1 5 cm	090	5.45	0/041	169	19	6	5	45	20	0.5	1	2
2009	24071	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater	090	5.70	0.045	183	33	12	15	45	20	0.5	1	1
2008	27062	Excision; trochanteric bursa or calcification	090	5.75	0.050	185	33	5	15	45	20	0.5		3

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2001	25651	Percutaneous skeletal fixation of ulnar styloid fracture	090	5.82	0.040	190	30			50	20	0.5	1	3
2005	20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	090	5.96	0.056	181	35	15	15	50	15	0.5		2
2005	15170	Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	090	5.99	0.013	220	20	20	10	30	20			
2004 MPC	19298	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance	000	6.00	0.059	169	30	15	15	60	30	0.5		
2009	64708	Neuroplasty, major peripheral nerve, arm or leg; other than specified	090	6.36	0.031	220	35	10	10	60	15	0.5	1	2
2001 MPC	57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	090	6.87	0.059	181	48			55	20	0.5	1	1
2009	26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	090	6.90	0.041	222	33	9	15	60	15	0.5	1	3
2009	27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	090	6.91	0.042	225	33	23	15	60	20	0.5	1	2
2005 MPC	30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	090	7.01	0.041	210.5	13.5	10	15	60	15	0.5	2	2
2000	38520	Biopsy or excision of lymph node(s); open, deep cervical node(s) with excision scalene fat pad	090	7.03	0.054	193	45			60	30	0.5	1	1
2009	24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	090	7.41	0.043	229	33	20	15	60	20	0.5	2	1
2000	46261	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy	090	7.76	0.038	241	60			70	30	0.5	2	1
2000	46288	Closure of anal fistula with rectal advancement flap	090	7.81	0.042	236	60			65	30	0.5	2	1
2001	24332	Tenolysis, triceps	090	7.91	0.051	230	50			60	30	0.5	1	3
2007	26665	Open treatment of CMC fracture dislocation, thumb (Bennett fracture), incl. internal fix, when performed	090	7.94	0.047	237	35	10	15	60	20	0.5	2	2
2005	49505	Repair initial inguinal hernia, age 5 years or	090	7.96	0.065	198	20	15	15	70	20	0.5	1	1

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

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
MPC		older; reducible												
2008	25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	090	8.08	0.056	235	40	10	15	60	20	0.5	1	3
2008 MPC	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet, defect 10 sq cm or less	090	8.60	0.050	223	15	10	5	90	25		2	2
2007	64910	Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve	090	11.39	0.067	264	25	10	15	90	20	0.5	3	1

The RUC reaffirms its recommendation of 6.36 for CPT Code 42440.

#### April 2008 RUC Recommendations

CPT codes 64708, *Neuroplasty, major peripheral nerve, arm or leg; other than specified*, and 64712, *Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve*, were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the re-evaluation of Site of Service Anomalies.

Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase the work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society commented that the current physician time and work RVU data for 64708 is based on a Harvard survey of 7 orthopaedic surgeons. Podiatrists, plastic surgeons, and hand surgeons were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (from orthopaedic surgeons and the post-operative visits were predicted by CMS using an algorithm rather than a survey. One of the RUC's compelling evidence standards is that "a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data." Current Medicare utilization data indicate that orthopaedic surgery is the primary provider for 64708 (33%), but not the only provider. For the current RUC survey, orthopaedic surgeons and plastic surgeons and their subspecialties were surveyed. Because there is not compelling evidence to review the work RVU with consideration for an increase, the specialty society provided data to support that the service is appropriately valued with its current work RVU of 6.22.

The specialty society provided the results of a survey of 82 orthopaedic, hand, plastic, and foot and ankle surgeons to the RUC. Based on the survey results, the presenters recommended pre-service evaluation time of 35 minutes, pre-service positioning time of 10 minutes, and pre-service scrub, dress and wait time of 10 minutes. The median intra-service time is 60 minutes. The specialty society agreed that the primary site of service is the outpatient setting and that this service would not typically require an overnight stay. The specialty society then recommended and the RUC agreed with one-half 99238 discharge day management service, three 99212, and one 99213 office visits within the 090 day global period of 67408. The survey also resulted in a median work RVU of 10.00 and a 25<sup>th</sup> percentile work RVU of 8.50. The survey respondents selected 64910, *Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve* (work RVU = 11.21, intra-service time = 90 minutes) as a key reference service. The RUC noted that the intra-service time for 64910 was too high for the RUC to use as a comparison and instead considered several other reference services including, 19298, *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance*, (work RVU = 6.00, intra-service time = 60 minutes) and 30520, *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (work RVU = 6.85, intra-service time = 60 minutes). Therefore, the RUC agreed that the current value of 6.22 (6.36 in 2010) is not overvalued and is an appropriate work RVU for the service.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
64708	Neuroplasty, major peripheral nerve, arm or leg; other than specified	090	6.36 (No Change)

August 16, 2010

Barbara Levy, MD  
Chair, AMA/Multi-specialty Relative Value Update (RUC) Committee  
American Medical Association  
515 N. State St.  
Chicago, IL 60610

RE: Tab 69-64708, Neuroplasty, Leg or Arm

Dear Dr. Levy,

In the Proposed Rule for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC "re-review" the RUC recommendations for existing CPT codes, originally identified as site-of-service anomalies. The RUC requested that each specialty society prepare a letter and supporting documents explaining why the listed codes are appropriately valued and explain why the methodology described by CMS would not result in a substantially different work RVU from the previously submitted RUC recommendation.

In January of 2008, the American Academy of Orthopaedic Surgery, the American Society for Surgery of the Hand, the American Society of Plastic Surgeons, the American Podiatric Medical Association, and the American Orthopaedic Foot and Ankle Society conducted a standard RUC survey for code 64708 Neuroplasty, major peripheral nerve, arm or leg; other than specified. The survey results were presented by the societies at the April 2008 RUC meeting. This was in response to a "site-of-service" anomaly based on the CMS data indicating more than 50% of the procedures were being discharged from outpatient facilities while the value included inpatient facility visits. We collected 82 total responses and recommended no change in the work RVU. Our recommendation was based on magnitude estimation comparing 64708 to key reference code 64910, as well as two MPC codes, 19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance, (work RVU = 6.00, intra-service time = 60 minutes) and 30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft (work RVU = 6.85, intra-service time = 60 minutes). Based on these comparison codes, the societies felt the then current RVW of 6.22 was ranked appropriately with an IWP/UT of 0.031 being extremely low for a major surgical procedure.

The specialty societies commented at the time of the presentation that 64708 had been previously valued under the Harvard study, and the inputs were based on comparisons to orthopaedic procedures and reviewed by orthopaedic surgeons. Since the time of Harvard, the mix of providers has changed considerably with orthopaedics providing 38.55% of the procedures done on Medicare patients in 2008, but with plastic and reconstructive surgeons doing 22.84% and Podiatry 14.83%. One of the compelling evidence standards for requesting increases in work value under RUC rules is a different mix of dominant providers and we felt that 64708 met this threshold. Despite this fact, we recommended maintaining the current value, even at a low intensity level. The RUC supported this recommendation.

We also noted that if a surgeon spent the total time for 64708 (220 min) performing 99213 E/M services (23 minutes), then the total RVWs would be 38% or 2.44 RVUs greater.  $[(220 \text{ min for } 25116) / (23 \text{ min for } 99213)] \times (0.92 \text{ RVUs for } 99213) = 8.80 \text{ RVUs}$ .

At this time, we would like to present additional information to support the current work RVU. During the Harvard study of 64708, only estimates for time were captured. Time was multiplied by assigned intensities to calculate total work, which was then transformed to work relative value units (ie, the building block methodology, as use by Harvard).

We emphasize that Harvard study estimates were for time. Number and level of hospital and/or office visits were imputed by a CMS contractor for purposes of reviewing practice expense RVUs many years after completion of the Harvard study. Additionally, we also note that for many of the codes, pre- and post-time was predicted using an algorithm that took into account the surveyed intra-service time and the pre- and post-times of an anchor code. Given this information, it should be clear that work RVUs for visits in current survey data should not be added and/or subtracted from the work RVU for 64708 because time, not visits, was used as building blocks to calculate the initial work RVU.

We disagree with the methodology that CMS describes as "reverse building block." The methodology described is flawed in that it compares apples (Harvard minutes) to oranges (imputed E/M visits). It is no wonder that the Agency's calculations for some codes result in negative work, since the Agency was mixing data elements incorrectly. The building block for 64708 involved time and assigned intensities followed by technical expert group review that did not include some of the now dominant providers and then CMS refinement panels as necessary through magnitude estimation. The RUC's review of 64708 also utilized magnitude estimation to determine whether the current value for the code was supported. We also note that the Agency's flawed methodology results in a difference of (-0.05) work RVUs for 64708. For 20 years, peer-review and CMS refinement of codes has never resulted in such a minor incremental adjustment based on a calculation.

As participants of the RUC review process, we believe magnitude estimation is a more valid methodology than reverse building block, and we continue to support the RUC's previous recommendation to maintain the current value for 64708.

In addition to the key reference code 64910, we present a table of codes on the following page that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IPUT. We believe a review – by magnitude estimation – of this list of procedures adds further support that the current work RVU for 64708 is not over-valued, as CMS suggests.

Sincerely,

William Creevy, MD  
Advisor, American Academy of Orthopaedic Surgery

**Daniel Nagle, MD**  
Advisor, American Society for Surgery of the Hand

**Martha Mathews, MD**  
Advisor, American Society of Plastic Surgeons

**Seth Rubenstein, DPM**  
Advisor, American Podiatric Medical Association

**Tye Ouzounian, MD**  
Advisor, American Orthopaedic Foot and Ankle Society

CC: RUC 5-Year ID Workgroup

**RUC-Reviewed Comparison Codes to Support the Current Work RVU of Code 25116**

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IINPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2009	21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	090	5.42	0.043	174	33	8	15	45	15	0.5	1	1
2009	28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	090	5.45	0.041	169	19	6	5	45	20	0.5	1	2
2009	24071	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater	090	5.70	0.045	183	33	12	15	45	20	0.5	1	1
2008	27062	Excision; trochanteric bursa or calcification	090	5.75	0.050	185	33	5	15	45	20	0.5		3
2001	25651	Percutaneous skeletal fixation of ulnar styloid fracture	090	5.82	0.040	190	30			50	20	0.5	1	3
2005	20680	Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	090	5.96	0.056	181	35	15	15	50	15	0.5		2
2005	15170	Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	090	5.99	0.013	220	20	20	10	30	20			
2004 MPC	19298	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance	000	6.00	0.059	169	30	15	15	60	30	0.5		
2009	64708	Neuroplasty, major peripheral nerve, arm or leg; other than specified	090	6.36	0.031	220	35	10	10	60	15	0.5	1	2
2001 MPC	57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy	090	6.87	0.059	181	48			55	20	0.5	1	1
2009	26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon	090	6.90	0.041	222	33	9	15	60	15	0.5	1	3
2009	27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	090	6.91	0.042	225	33	23	15	60	20	0.5	1	2
2005 MPC	30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	090	7.01	0.041	210.5	13.5	10	15	60	15	0.5	2	2
2000	38520	Biopsy or excision of lymph node(s), open, deep cervical node(s) with excision scalene fat pad	090	7.03	0.054	193	45			60	30	0.5	1	1
2009	24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	090	7.41	0.043	229	33	20	15	60	20	0.5	2	1
2000	46261	Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fissurectomy	090	7.76	0.038	241	60			70	30	0.5	2	1
2000	46288	Closure of anal fistula with rectal advancement flap	090	7.81	0.042	236	60			65	30	0.5	2	1
2001	24332	Tenolysis, triceps	090	7.91	0.051	230	50			60	30	0.5	1	3
2007	26665	Open treatment of CMC fracture dislocation, thumb (Bennett fracture), incl. internal fix, when performed	090	7.94	0.047	237	35	10	15	60	20	0.5	2	2
2005 MPC	49505	Repair initial inguinal hernia, age 5 years or older; reducible	090	7.96	0.065	198	20	15	15	70	20	0.5	1	1
2008	25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	090	8.08	0.056	235	40	10	15	60	20	0.5	1	3
2008 MPC	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	090	8.60	0.050	223	15	10	5	90	25		2	2

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Last Year Before RUC	2008 RVU Review	Pre-Service Utilization	Pre-Service Evaluation	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75			75	120	43	2	2	2	1	1	1	1	428	0.0145		Pre-RUC Evaluation	
		10.03	2010	1,123	60	10	15	85	90	30	2	2						283	0.0530	AAOMS	Post-RUC Evaluation
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49			49	62	23		3.5		0.5		1	1	238	0.0886		Pre-RUC Evaluation	
		9.23	2010	1,237	40	15	15	70	60	20	2.0	2.0			0.5	0.5	247	0.0648	AAOS	Post-RUC Evaluation	
25116	REMOVE WRIST/FOREARM LESION	7.38	2009	36			36	78	21		5.0		1.5		1.0	1.0	283	0.0192		Pre-RUC Evaluation	
		7.56	2010	1,030	40	10	15	65	60	20		1.0	3.0			0.5	249	0.0307	ASPS	Post-RUC Evaluation	
27792	TREATMENT OF ANKLE FRACTURE	7.91	2007	21	25		83	19	4.0		1.5		1.0								Pre-RUC Evaluation
		9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0	1.0		1.0	1.0	281	0.0513	AAOS, AOFAS	Post-RUC Evaluation	
28120	PART REMOVAL OF ANKLE/HEEL	5.64	2009	47			47	67	21		3.5		1.5		1.0	1.0	259	0.0056		Pre-RUC Evaluation	
		8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0	1.0		1.0	1.0	280	0.0263	AAOS, APMA	Post-RUC Evaluation	
28122	PARTIAL REMOVAL OF FOOT BONE	7.56	2009	43			43	51	26		5.0		1.5		1.0	1.0	268	0.0304		Pre-RUC Evaluation	
		7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0	1.0		1.0	1.0	264	0.0249	AAOS, APMA	Post-RUC Evaluation	
28725	FUSION OF FOOT BONES	11.97	2009	50			50	89	22		4.0		2.5		1.0	1.0	313	0.0631		Pre-RUC Evaluation	
		12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0		1.0	1.0	339	0.0496	AAOS	Post-RUC Evaluation	
28730	FUSION OF FOOT BONES	12.21	2009	60			60	120			5.0		1.0		1.0	1.0	383	0.0331		Pre-RUC Evaluation	
		12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0		1.0	1.0	349	0.0471	AOFAS, APMA, AAOS	Post-RUC Evaluation	
28825	PARTIAL AMPUTATION OF TOE	3.71	2008	17			25	42	36	16	3.5		0.5		1.0	1.0	198	0.0151		Pre-RUC Evaluation	
		6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0	1.0		1.0	1.0	224	0.0099	AAOS	Post-RUC Evaluation	
36821	AV FUSION DIRECT ANY SITE	9.15	2008	29			25	54	75	28	2.5		1.5		1.0	1.0	265	0.0540		Pre-RUC Evaluation	
		12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0			1.0	1.0	256	0.0823	ACS, SVS, RPA	Post-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAPH	10.00	2009	56			56	81	22		2.5		1.0		1.0	1.0	257	0.0663		Pre-RUC Evaluation	
		15.13	2010	4,873	40	10	20	70	120	30	10	2.0	1.0		1.0	1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation	
42415	EXCISE PARTOID GLAD/LESION	17.99	2009	55			55	156	37		3.5		1.5		1.0	1.0	396.5	0.0671		Pre-RUC Evaluation	
		18.12	2010	4,464	40	12	20	72	150	20	1.0				1.0	1.0	342	0.0843	ACS, AAO-HNS	Post-RUC Evaluation	
42420	EXCISE PARTOID GLAD/LESION	20.87	2009	57			57	182	22		3.5		3.0		1.0	1.0	439.5	0.0687		Pre-RUC Evaluation	
		21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0		1.0	1.0	432	0.0743	ACS, AAO-HNS	Post-RUC Evaluation	
42440	EXCISE SUBMAXILLARY GLAND	7.05	2009	47			47	71	19		1.5		0.5		1.0	1.0	209	0.0500		Pre-RUC Evaluation	
		7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0			0.5	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation		
49507	PRP I/HERN INIT BLOCK >5 YR	9.97	2009	45			45	67.5	30	1.0	1.0	1.0		1.0	1.0	1.0	239.5	0.0711		Pre-RUC Evaluation	
		10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0	1.0		1.0	1.0	260	0.0680	ACS	Post-RUC Evaluation	
49521	REREPAIR ING HERNIA, BLOCKED	12.36	2009	45			45	90	30	1.0	1.0	1.0		1.0	1.0	1.0	262	0.0799		Pre-RUC Evaluation	
		12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0	1.0		1.0	1.0	280	0.0795	ACS	Post-RUC Evaluation	
49587	RPR UNBIL HERN, BLOCK >5 YR	7.96	2009	45			45	60	30	1.0	1.0	1.0		1.0	1.0	1.0	232	0.0465		Pre-RUC Evaluation	
		8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0	1.0		1.0	1.0	250	0.0459	ACS	Post-RUC Evaluation	
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010	45	15	15	75	90	30	1.0	1.0	1.0		1.0	1.0	1.0	292	0.0806	ACS	New Code in 2009	
49653	LAP VENT/ABD HERN PROC COMP	16.21	2010	45	15	15	75	120	30	2.0	1.0	1.0		1.0	1.0	1.0	378	0.0726	ACS	New Code in 2009	
49654	LAP INC HERNIA REPAIR	15.03	2010	45	15	15	75	120	30	1.0	1.0	1.0		1.0	1.0	1.0	362	0.0668	ACS	New Code in 2009	
49655	LAP INC HERN REPAIR COMP	18.11	2010	50	15	15	80	150	30	2.0	1.0	1.0		1.0	1.0	1.0	413	0.0700	ACS	New Code in 2009	
52341	CYSTO W/URETER STRICTURE TX	6.11	2008	47.5			47.5	60	49								156.5	0.0658		Pre-RUC Evaluation	
		5.35	2010	2,105	45	10	15	70	45	20							135	0.0789	AUA	Post-RUC Evaluation	
52342	CYSTO W/UP STRICTURE TX	6.61	2008	60			60	65	30				1.0				175	0.0590		Pre-RUC Evaluation	
		5.85	2010	281	40	10	10	60	60	20							140	0.0700	AUA	Post-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	7.31	2008	60			60	90	30				1.0				200	0.0504		Pre-RUC Evaluation	
		6.55	2010	37	45	10	10	65	60	25							150	0.0780	AUA	Post-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.81	2008	60			60	77.5	30				1.0				187.5	0.0650		Pre-RUC Evaluation	
		7.05	2010	2,447	40	10	10	60	45	20							125	0.1200	AUA	Post-RUC Evaluation	
52345	CYSTO/URETERO W/UP STRICTURE	8.31	2008	50			50	90	30				1.0				190	0.0640		Pre-RUC Evaluation	
		7.55	2010	475	45	10	15	70	45	20							135	0.1277	AUA	Post-RUC Evaluation	
52346	CYSTOURERETO W/RENAL STRICT	9.34	2008	45			45	120	49								214	0.0603		Pre-RUC Evaluation	
		8.58	2010	144	40	10	10	60	60	20							140	0.1155	AUA	Post-RUC Evaluation	
52400	CYSTOURERETO W/CONGEN REPR	10.06	2008	90			90	60	30	1.0	1.0	1.0		1.0	1.0	1.0	261	0.0727		Pre-RUC Evaluation	
		8.69	2010	635	72.5	10	15	97.5	40	25	1.0			0.5	197.5	0.1260	AUA	Post-RUC Evaluation			
52500	REVISION OF BLADDER NECK	9.39	2008	40			40	45	35		3.0		1.0		1.0	1.0	247	0.0613		Pre-RUC Evaluation	
		8.14	2010	5,348	45	10	15	70	45	27.5		3.0		0.5	0.5	230.5	0.0582	AUA	Post-RUC Evaluation		
52640	RELIEVE BLAD CONTRACTION	6.89	2008	50			50	39	17		20		10		10	10	216	0.0509		Pre-RUC Evaluation	
		4.79	2010	2,217	40	10	10	60	30	20	2.0		0.5	0.5	0.5	0.5	161.5	0.0514	AUA	Post-RUC Evaluation	

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review
											99211	99212	99213	99214	99231	99232	99233	99238				
53445	INSERT URO/VES NCK SPHINCTER	15.21	2009	75				75	126	24	3.0	3.0	3.0	3.0	1.0	1.0	1.0	1.0	392	0.0546		Pre-RUC Evaluation
		15.39	2010	1,949	50	15	20	85	90	25	1.0	3.0			1.0	1.0	1.0	1.0	418	0.0572	AUA	Post-RUC Evaluation
54410	REMOVE/REPLACE PENIS PROSTH	16.48	2008	50				50	145	30	2.0	1.0	1.0						369	0.0635		Pre-RUC Evaluation
		15.18	2010	1,328	40	10	15	65	120	30	1.0	3.0							338	0.0716	AUA	Post-RUC Evaluation
54530	REMOVAL OF TESTIS	9.31	2008	58				58	58	17	2.5	0.5			1.0	238.5	0.0673		Pre-RUC Evaluation			
		8.46	2010	1,426	57.5	10	15	82.5	60	30	2.0	1.0			0.5	246.5	0.0597	AUA	Post-RUC Evaluation			
57287	REVISE/REMOVE SLING REPAIR	11.49	2008	45				45	70	30	1.0	2.0	2.0		1.0	285	0.0656		Pre-RUC Evaluation			
		11.15	2010	1,795	40	10	10	60	60	20	1.0	3.0			0.5	244	0.0912	AUA, ACCG	Post-RUC Evaluation			
61885	INSRT/REDO NEUROSTIM ARRAY	7.37	2009	50				50	60	25	4.0	1.0	1.0		1.0	325	0.027		Pre-RUC Evaluation			
		6.44	2010	4,366	33	3	15	51	45	20		2.0			0.5	181	0.0661	AANS/CNS	Post-RUC Evaluation			
		6.41	2009		40			40	30	20	2.0	2.0			1.0	200	0.0435		Pre-RUC Evaluation			
62263	EPIDURAL LYSIS MULT SESSIONS	6.54	2010	1,269	33	10	5	48	45	20	1.0	2.0			0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation			
		8.04	2008		70			70	60	125	4.0		1.0		2.0	1.0	487	-0.0715		Pre-RUC Evaluation		
62350	IMPLANT SPINAL CANAL CATH	6.05	2010	6,416	33	10	5	48	60	20		1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
		6.60	2008		60			60	40	130	3.0		1.0		2.0	1.0	446	-0.1284		Pre-RUC Evaluation		
62355	REMOVE SPINAL CANAL CATHETER	4.35	2010	1,461	33	10	5	48	30	20		1.0			0.5	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
		3.68	2008		60			60	55	123	4.0				2.0	10	450	-0.1385		Pre-RUC Evaluation		
62360	INSERT SPINE INFUSION DEVICE	4.33	2010	616	33	10	5	48	60	20		1.0			0.5	170	0.0211	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation			
		6.59	2008		60			60	60	130	4.0		1.0		2.0	10	482	-0.0938		Pre-RUC Evaluation		
62361	IMPLANT SPINE INFUSION PUMP	5.65	2010	307	33	10	5	48	60	20		1.0			0.5	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
		8.58	2008		75			75	90	150	4.0				3.0	1.0	582	-0.0629		Pre-RUC Evaluation		
62362	IMPLANT SPINE INFUSION PUMP	6.10	2010	6,570	33	10	5	48	60	20		1.0			0.5	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation			
		6.57	2008		60			60	45	125	3.0		1.0		2.0	1.0	446	-0.1123		Pre-RUC Evaluation		
62365	REMOVE SPONE INFUSION DEVICE	4.65	2010	1,598	33	10	5	48	45	20		1.0			0.5	155	0.0353	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation			
		7.57	2008		56			56	74	19		2.0	2.5		1.0	283	0.0152		Pre-RUC Evaluation			
63650	IMPLANT NEUROELECTRODES	7.20	2010	31,144	33	10	5	48	60	20		1.0			0.5	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
		7.87	2008		53			53	62	18		2.0	2.5		1.0	267	0.0245		Pre-RUC Evaluation			
63685	INSRT/REDO SPINE N GENERATOR	6.05	2010	9,343	33	10	5	48	60	20		1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
		6.22	2009		46			46	76	18	2.5		0.5		1.0	228	0.0301		Pre-RUC Evaluation			
64708	REVISE ARM/LEG NERVE	6.36	2010	3,069	35	10	10	55	60	15	3.0	1.0			0.5	220	0.0314	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation			
		10.23	2008		50	--	--	50	74	21		2.5	1.0		1.0	260.5	0.0612		Pre-RUC Evaluation			
64831	REPAIR OF DIGIT NERVE	9.16	2010	972	40	10	15	65	60	15	2.0	2.0			0.5	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation			
		14.43	2009		52			52	79	32		5.5	0.5		1.0	337.5	0.0730		Pre-RUC Evaluation			
65285	REPAIR OF EYE WOUND	14.71	2010	1,154	37		15	52	79	32		5.5	0.5		1.0	337.5	0.0766	AAO	Post-RUC Evaluation			
<i>Codes to be reviewed on the four-year review agenda (52640 and 57287) and recent May 2010 submission (61885)</i>																						
23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values																						
*2010 Post-RUC Review work RVWs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10																						

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalign les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11179 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	- 0.44 RVUs	0.38 RVUs ...	- 0.76 RVUs	- 1.39 RVUs	- 0.64 RVUs	- 0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39) = -0.64 - 0.36 = 8.08$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insrt/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insrt/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup> We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IPUT is counterintuitive to the IPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

April 2008

**Neuroplasty-Leg or Arm**

CPT codes 64708, *Neuroplasty, major peripheral nerve, arm or leg; other than specified*, and 64712, *Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve*, were identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated for physician work. At the February 2008 RUC meeting, the RUC established a series of procedural rules to guide the reevaluation of Site of Service Anomalies. Included in these procedural guidelines is the necessity of compelling evidence for any specialty society recommendation to increase work RVU for a Site of Service Anomaly.

At the April 2008 RUC meeting, the specialty society commented that the current physician time and work RVU data for 64708 is based on a Harvard survey of 7 orthopaedic surgeons. Podiatrists, plastic surgeons, and hand surgeons were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (from orthopaedic surgeons and the post-operative visits were predicted by CMS using an algorithm rather than a survey. One of the RUC's compelling evidence standards is that "a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data." Current Medicare utilization data indicate that orthopaedic surgery is the primary provider for 64708 (33%), but not the only provider. For the current RUC survey, orthopaedic surgeons and plastic surgeons and their subspecialties were surveyed. Because there is not compelling evidence to review the work RVU with consideration for an increase, the specialty society provided data to support that the service is appropriately valued with its current work RVU of 6.22.

The specialty society provided the results of a survey of 82 orthopaedic, hand, plastic, and foot and ankle surgeons to the RUC. Based on the survey results, the presenters recommended pre-service evaluation time of 35 minutes, pre-service positioning time of 10 minutes, and pre-service scrub, dress and wait time of 10 minutes. The median intra-service time is 60 minutes. The specialty society agreed that the primary site of service is the outpatient setting and that this service would not typically require an overnight stay. The specialty society then recommended and the RUC agreed with one-half 99238 discharge day management service, three 99212, and one 99213 office visits within the 090 day global period of 67408. The survey also resulted in a median work RVU of 10.00 and a 25<sup>th</sup> percentile work RVU of 8.50. The survey respondents selected 64910, *Nerve repair; with synthetic conduit or vein allograft (eg,*

*nerve tube), each nerve* (work RVU = 11.21, intra-service time = 90 minutes) as a key reference service. The RUC noted that the intra-service time for 64910 was too high for the RUC to use as a comparison and instead considered several other reference services including, 19298, *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance*, (work RVU = 6.00, intra-service time = 60 minutes) and 30520, *Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft* (work RVU = 6.85, intra-service time = 60 minutes). Therefore, the RUC agreed that the current value of 6.22 is not overvalued and is an appropriate work RVU for the service.

**The RUC recommends maintaining the current work RVU of 6.22 and implementing the recommended times and post-operative visits.**

#### **64712**

Code 64712 describes a procedure for neuroplasty of the sciatic nerve. The specialty society expert consensus panel noted a significant shift from 1999 to 2005 in the providers reporting this operative procedure. The panel believes there is an issue with reporting (at least in the Medicare database) that erroneously changes the site of service for this code. Literature describes a minimally invasive epidural catheter procedure using a Racz catheter as "epidural neuroplasty" - hypothesized principle of action is local epidural lysis of adhesions, neurolysis of vertebral nerve roots and local lavage of proinflammatory mediators by repeated injection of local anesthetics, corticosteroids, hyaluronidase and hypertonic saline solution. However, neuroplasty is surgery to repair or restore nerve tissue. Neuroplasty of the sciatic nerve requires an incision, exploration/dissection and decompression/repair. This is not the same work as injection by catheter of a neurolytic agent for lysis of adhesions. The specialty society has identified this as a CPT issue requiring new codes for catheter injection, not only of the sciatic nerve, but also of the lumbar plexus (ie, code 64714) which also appears to have the same shift in reporting since the introduction of the Racz catheter. **The RUC agreed and recommended that this service be referred to the CPT Editorial Panel for revision.**

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
64708	Neuroplasty, major peripheral nerve, arm or leg; other than specified	090	6.22
64712	sciatic nerve	090	Request Referral to CPT Editorial Panel

## **AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS SUMMARY OF RECOMMENDATION**

CPT Code:64708      Tracking Number n/a      Specialty Society Recommended RVU: 6.22  
Global Period: 090      RUC Recommended RVU: 6.22

CPT Descriptor: Neuroplasty, major peripheral nerve, arm or leg; other than specified

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**CLINICAL DESCRIPTION OF SERVICE:**

### Vignette Used in Survey:

## UPPER EXTREMITY:

A 45-year-old woman with a right posterior interosseous nerve compression undergoes decompression of the posterior interosseous nerve of the right forearm.

## LOWER EXTREMITY:

A 45-year-old woman with a right peroneal nerve compression undergoes decompression of the nerve.

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 19%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 4%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

### Description of Pre-Service Work:

## **UPPER EXTREMITY:**

- Write preadmission orders for preoperative medications
  - Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
  - Perform 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.
  - Scrub and gown.
  - The arm is draped.
  - The arm is elevated and exsanguinated.
  - The pneumatic tourniquet is inflated.
  - Perform surgical "time out" with operating surgical team

## LOWER EXTREMITY:

- Write preadmission orders for preoperative medications
  - Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.

- Perform 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 leg is placed properly on the table and positioned with proper bolstering to aid surgical exposure.
- Indicate areas of skin to be prepped and mark surgical incisions
- A tourniquet is placed on the proximal thigh
- The leg is prepped and draped.
- The leg 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:

**UPPER EXTREMITY:**

The forearm is pronated and a 10-cm straight skin incision is made along a line extending from the lateral epicondyle to Lister's tubercle. The posterior cutaneous nerve of the forearm is identified and protected. The forearm fascia is incised in the interval between the extensor digitorum communis and the radial wrist extensors. The extensor digitorum communis muscle is detached from the lateral epicondyle as needed. The supinator is identified deep to the extensor muscles in the proximal third of the incision. The posterior interosseous nerve is found at the proximal edge of the supinator, and the fibrous leading edge of the extensor carpi radialis brevis and the tendinous leading edge of the supinator are released. The recurrent leash of Henry vessels is ligated. The superficial head of the supinator muscle is released to its distal border. The branches of the posterior interosseous nerve are examined and decompressed as needed. The tourniquet is released and meticulous hemostatic achieved. The wound is irrigated and closed in layers.

**LOWER EXTREMITY:**

Under anesthesia, an incision is made over the peroneal nerve. Neurovascular structures are identified and protected. The nerve is identified and soft tissue constrictions are released. The tourniquet is deflated and hemostasis is obtained. The wound is inspected and irrigated. The wound is closed in layers.

Description of Post-Service Work:

**UPPER EXTREMITY:**

Post-service work: in facility

- Application of bulky dressing, reinforced with long arm splint
- Monitor 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.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

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

**LOWER EXTREMITY:****Post-service work: in facility**

- Application of a dressing and short leg splint
- Monitor 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 circulation, sensation and motor function of the operated extremity are assessed.
- Orders are written for evaluation of periodic imaging and laboratory reports; review of anticoagulation laboratory values and appropriate medication adjustment, and antibiotic and pain medication adjustments
- Home restrictions (ie, activity, bathing) are discussed with the patient and family members
- Physical therapy for the uses of crutches or walker is ordered
- Write prescriptions for medications needed post-discharge.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

**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 physical 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)	02/2008					
Presenter(s):	Daniel Nagle, MD; Dale Blasier, MD; Scott Oates, MD; Tye Ouzounian, MD					
Specialty(s):	orthopaedic surgery, plastic surgery, hand surgery, orthopaedic foot and ankle surgery					
CPT Code:	64708					
Sample Size:	300	Resp N:	82	Response: 27.3 %		
Sample Type:	Random					
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>	<u>High</u>
Service Performance Rate		0.00	1.00	2.00	4.00	36.00
Survey RVW:		4.20	8.50	10.00	11.20	20.00
Pre-Service Evaluation Time:				35.0		
Pre-Service Positioning Time:				10.0		
Pre-Service Scrub, Dress, Wait Time:				10.0		
Intra-Service Time:		20.00	45.00	60.00	60.00	120.00
Immediate Post Service-Time:	<u>15.00</u>					
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.50	99239x 0.00			
Office time/visit(s):	<u>71.0</u>	99211x 0.0	12x 3.0	13x 1.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

CPT Code:	64708					
		<u>Specialty Recommended</u>				
Physician Work RVU:		6.22				
Pre-Service Evaluation Time:		35.0				
Pre-Service Positioning Time:		10.0				
Pre-Service Scrub, Dress, Wait Time:		10.0				
Intra-Service Time:		60.00				
Immediate Post Service-Time:	<u>15.00</u>					
<u>Post Operative Visits</u>	<u>Total Min**</u>	<u>CPT Code and Number of Visits</u>				
Critical Care time/visit(s):	<u>0.0</u>	99291x 0.0	99292x 0.0			
Other Hospital time/visit(s):	<u>0.0</u>	99231x 0.0	99232x 0.0	99233x 0.0		
Discharge Day Mgmt:	<u>19.0</u>	99238x 0.5	99239x 0.0			
Office time/visit(s):	<u>71.0</u>	99211x 0.0	12x 3.0	13x 1.0	14x 0.0	15x 0.0
Prolonged Services:	<u>0.0</u>	99354x 0.0	55x 0.0	56x 0.0	57x 0.0	

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64910	090	11.21	RUC Time

CPT Descriptor Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>	<u>Medicare Utilization</u>	<u>Work RVU</u>	<u>Time Source</u>
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CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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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: 19.5 %**

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> 64708	<u>Key Reference CPT Code:</u> 64910	<u>Source of Time</u> RUC Time
Median Pre-Service Time	55.00	50.00	
Median Intra-Service Time	60.00	90.00	
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	19.0	19.00	
Median Office Visit Time	71.0	85.00	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>220.00</b>	<b>264.00</b>	
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	4.06	3.27
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.88	3.53
--	------	------

Urgency of medical decision making	3.13	3.71
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**Technical Skill/Physical Effort (Mean)**

Technical skill required	4.44	4.27
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Physical effort required	3.69	3.60
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**Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	4.13	3.73
---	------	------

Outcome depends on the skill and judgment of physician	4.50	4.40
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.53
--	------	------

**INTENSITY/COMPLEXITY MEASURES**

CPT Code      Reference  
Service 1

**Time Segments (Mean)**

Pre-Service intensity/complexity	3.73	3.62
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Intra-Service intensity/complexity	4.33	4.46
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Post-Service intensity/complexity	3.40	3.46
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**Additional Rationale**

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

Current data for 64708 (2008 RVW=6.22) is based on a Harvard survey of 7 orthopaedic surgeons. Podiatrists, plastic surgeons, and hand surgeons were not included in the Harvard study. Additionally, Harvard only surveyed intra-service time (of orthopaedic surgeons) and the post-op visits were predicted by a CMS contractor (Dan Dunn) using an algorithm (not survey). The current Harvard-based RVW (6.22) and Harvard data result in a low IPUT = 0.031.

One of the RUC's compelling evidence standards is that "a previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data." Current Medicare utilization data indicate that orthopaedic surgery is the primary provider for 64708 (37%), but not the only provider. For the current RUC survey, orthopaedic surgeons and plastic surgeons and their subspecialties were surveyed.

Code 64708 describes a procedure for "other than specified" major peripheral nerve – arm or leg. The expert panel reviewing the survey data noted that in any given year, this imprecise code can be used in varying frequency by various specialty surgeons/physicians performing work on the upper or lower extremity. For example, Table 1 below shows the Medicare distribution of specialties in 1999 – contrasted by Table 2 which shows the Medicare distribution of specialties in 2005.

Table 1 – 1999 Distribution	
orthopaedic surgery	52%
plastic surgery	11%
hand surgery	10%
neurosurgery	9%
general surgery	5%
group practice	5%
podiatry	2%
Other	5%

Table 2 – 2005 Distribution	
orthopaedic surgery	37%
podiatry	26%
plastic surgery	20%
hand surgery	7%
neurosurgery	5%
general surgery	2%
other	3%

Because the service is infrequently performed – and by very different specialties, two vignettes were used – one for upper extremity specialties (ASSH) and one for lower extremity (AOFAS) specialties. Additionally, AAOS and ASPS sent the surveys randomly to general orthopaedic surgeons and peripheral nerve surgeons.

There was no difference in median intra-time or post-service work (facility and office) between upper extremity and lower extremity survey responses. The responses included the following specialties and counts: general orthopaedic =57; hand surgery =32; foot and ankle surgery =19; and plastic surgery =8.

Our expert consensus panel agrees with the median survey facility visit data that indicates the typical patient is discharged from a facility on the day of the procedure.

In comparison to the key reference code 64910 (Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve), the survey code 64708 is less total work, especially with respect to intra-operative time.

How many RVWs would you get if you spent the same amount of minutes doing 99213s?  
 $(220 \text{ min for 64708}) / (23 \text{ min for 99213}) \times (0.92 \text{ RVWs for 99213}) = 8.80 \text{ RVWs}$

Given a IPUT (0.031) for 64708 using the current RVW and the recommended time and visit information, **there is no evidence to indicate 64708 is overvalued at 6.22 RVWs.** We also find that if a surgeon spent the total time for 64708 (220 min) performing 99213 E/M services (23 minutes), then the total RVWs would be 41% greater or 2.58 RVUs greater.  $[(220 \text{ min for 27690}) / (23 \text{ min for 99213}) \times (0.92 \text{ RVUs for 99213}) = 8.80 \text{ RVUs}]$ .

#### Additional Supporting References:

CPT	descriptor	08RVW	TOTAL TIME	INTRA TIME
<b>58562</b>	Hysteroscopy, surgical; with removal of impacted foreign body	<b>5.20</b>	90	<b>40</b>
<b>45385</b> <b>MPC</b>	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	<b>5.30</b>	74	<b>43</b>
<b>43260</b> <b>MPC</b>	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	<b>5.95</b>	86	<b>46</b>
<b>19298</b> <b>MPC</b>	Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent	<b>6.00</b>	169	<b>60</b>

	to) partial mastectomy, includes imaging guidance			
<b>64708</b> <b>MPC</b>	Neuroplasty, major peripheral nerve, arm or leg; other than specified	<b>6.22</b>	<b>220</b>	<b>60</b>
<b>52342</b> <b>MPC</b>	Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)	<b>6.61</b>	<b>175</b>	<b>65</b>
<b>30520</b> <b>MPC</b>	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	<b>6.85</b>	<b>211</b>	<b>60</b>
<b>67904</b> <b>MPC</b>	Repair of blepharoptosis; (tarsal) levator resection or advancement, external approach	<b>7.83</b>	<b>185</b>	<b>45</b>

## **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.

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64708

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty plastic surgery                              How often? Sometimes

Specialty hand surgery      How often? Sometimes

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 the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frquency not available

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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CPT Code: 64708

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,337  
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare 2006 data

Specialty orthopaedic surgery      Frequency 1100      Percentage 32.96 %

Specialty plastic surgery      Frequency 600      Percentage 17.98 %

Specialty hand surgery      Frequency 300      Percentage 8.99 %

Do many physicians perform this service across the United States? Yes

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### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 64708 - use current code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

April 1, 2008

William Rich, M.D. Chair  
AMA/Specialty Society RVS Update Committee (RUC)  
515 North State Street  
Chicago, IL 60610

RE: Tab 49, Site-of-Service code 64712

Dear Dr. Rich:

We are writing in regards to CPT code 64712, which is part of the RUC Site-of-Service review. A consensus panel of orthopaedic surgeons, plastic surgeons and podiatrists reviewed the survey results as well as the history for CPT code 64712, *Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve.*

Code 64712 describes a procedure for neuroplasty of the sciatic nerve. Our panel of noted a significant shift from 1999 to 2005 in the providers reporting this operative procedure. We believe there is an issue with reporting (at least in the Medicare database) that erroneously changes the site of service for this code. Literature describes a minimally invasive epidural catheter procedure using a Racz catheter as "epidural neuroplasty" - hypothesized principle of action is local epidural lysis of adhesions, neurolysis of vertebral nerve roots and local lavage of proinflammatory mediators by repeated injection of local anesthetics, corticosteroids, hyaluronidase and hypertonic saline solution. However, neuroplasty is surgery to repair or restore nerve tissue. Neuroplasty of the sciatic nerve requires an incision, exploration/dissection and decompression/repair. This is not the same work as injection by catheter of a neurolytic agent for lysis of adhesions. We believe this is a CPT issue requiring new codes for catheter injection, not only of the sciatic nerve, but also of the lumbar plexus (ie, code 64714) which also appears to have the same shift in reporting since the introduction of the Racz catheter.

Tables 1a/1b and 2a/2b below show the Medicare distribution of specialties and site of service for 1999 compared with 2005 for code 64712.

<b>Table 1a – 1999 Distribution</b>	
orthopaedic surgery	60%
neurosurgery	16%
anesthesiology	6%
plastic surgery	5%
other	5%
general surgery	2%

<b>Table 2a – 1999 Distribution</b>	
inpatient hospital	67%
outpatient hospital	30%
office	2%
ASC	1%

<b>Table 1b – 2005 Distribution</b>	
orthopaedic surgery	31%
anesthesia	26%
plastic surgery	19%
podiatry	13%
pain management	6%
other	5%

<b>Table 2b – 2005 Distribution</b>	
outpatient hospital	54%
inpatient hospital	27%
ASC	16%
office	4%

The Medicare claims data indicate that 4% of the claims occur in an office. The expert panel reviewing this code cannot imagine performing open neuroplasty on the sciatic nerve in an office setting. The Medicare physician fee schedule does not pay for this procedure in an office setting (ie, nonfacility payment is N/A).

Although the Medicare claims data in the RUC database indicate 27% inpatient hospital and 54% outpatient hospital, our expert consensus panel believes this data is incorrect due to reporting issues for a minimally invasive catheter procedure. Surgical patients will typically have an extensive incision with a drain and require close monitoring on the day of the procedure are kept in the hospital for continued monitoring at least overnight for bleeding and neurologic changes.

We recognize the RUC's desire to complete the site-of-service anomaly review. However, for CPT code 64712 as well as CPT code 64714 (not part of the site-of-service review but a similar code to 64712) we suggest that the RUC request CPT to clarify the use of codes 64712 and 64714, as we believe that neurolysis of adhesions is not the same as open neuroplasty. We recommend that CPT provide said clarification and any actions in time for inclusion in the 2010 Physician Fee Schedule.

We respectfully request referral to the CPT Editorial Panel for 64712 and 64714.

Sincerely,

R. Dale Blasier, MD  
AAOS RUC Advisor

Frank Spinosa, DPM  
APMA RUC Advisor

Tye Ouzounian, MD  
AOFAS RUC Advisor

Scott Oates, MD  
ASPS RUC Advisor

CC: Sherry Smith, AMA Director Physician Payment Policy & Systems  
Bernard Pfeifer, MD, AAOS RUC Representative  
Lloyd Smith, DPM, APMA RUC Representative, co-chair RUC HCPCS sub-Committee

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
February 2008 – Initial Review

**Neurorrhaphy-Finger**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT code 64831 *Suture of digital nerve, hand or foot; one nerve,,* the RUC asked the specialties to provide additional rationale regarding the appropriateness of the current work RVU of 9.16. The specialties' enclosed letter and table of comparison codes emphasize the need to use relativity in reviewing physician work. The specialties also explained that the Harvard study measured post-operative time and did not articulate visits. The visits were extrapolated later for practice expense purposes. The RUC notes that the specialty survey actually supported a higher work RVU (median = 10.50), however compelling evidence was not presented in February 2008. The survey times for 64831 are 65 minutes of pre-time, 60 minutes intra-time, 15 minutes post-time,  $\frac{1}{2}$  day discharge day management and 4 office visits. CPT code 64831 is similar in work to 37761 *Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg* (work RVU = 9.13, pre-time = 68 minutes; intra-time = 60 minutes, post-time=25 minutes,  $\frac{1}{2}$  day discharge day and 3 office visits) and 14060 *Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less* (work RVU = 9.23, pre-time = 30 minutes; intra-time = 60 minutes; post-time = 15 minutes and 4 office visits).

The RUC also reviewed a table of codes that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IPUT. This review using magnitude estimation comparison of work RVUs further supports the current work RVU for 64831.

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2008	<b>45171</b>	Excision of rectal tumor, transanal approach, not including muscularis propria (ie, partial thickness)	090	8.13	<b>0.076</b>	<b>209</b>	33	15	15	<b>45</b>	20	0.5	2	1
2005	<b>37722</b>	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	090	8.16	<b>0.074</b>	<b>198</b>	40	10	10	<b>60</b>	20	0.5	1	1

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRA	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2000 MPC	<b>43269</b>	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent	000	8.20	<b>0.093</b>	141	40			71	30			
2000	<b>38530</b>	Biopsy or excision of lymph node(s); open, internal mammary node(s)	090	8.34	<b>0.063</b>	206	45			73	30	0.5	1	1
2008	<b>54530</b>	Orchiectomy, radical, for tumor; inguinal approach	090	8.46	<b>0.060</b>	247	58	10	15	60	30	0.5	1	2
2005	<b>37184</b>	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	000	8.66	<b>0.080</b>	160	20	10	10	90	30			
2001	<b>25275</b>	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	090	8.96	<b>0.064</b>	223	40			70	23	0.5	1	3
2001	<b>29824</b>	Arthroscopy, shoulder, surgical, distal claviclectomy including distal articular surface (Mumford procedure)	090	8.98	<b>0.065</b>	225	48			60	20	0.5	2	2
2008	<b>37761</b>	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	090	9.13	<b>0.074</b>	224	33	10	15	60	25	0.5	2	1
2007	<b>50593</b>	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	010	9.13	<b>0.064</b>	217	45	10	10	90	20	0.5	1	
2008	<b>64831</b>	Suture of digital nerve, hand or foot; 1 nerve	090	9.16	<b>0.067</b>	237	40	10	15	60	15	0.5	2	2
2008 MPC	<b>14060</b>	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips, defect 10 sq cm or less	090	9.23	<b>0.090</b>	183	15	10	5	60	15		2	2
2008	<b>23415</b>	Coracoacromial ligament release, with or without acromioplasty	090	9.23	<b>0.065</b>	247	40	15	15	60	20	0.5	2	2
2000	<b>49555</b>	Repair recurrent femoral hernia; reducible	090	9.39	<b>0.066</b>	218	45			85	30	0.5	1	1
2007	<b>29906</b>	Arthroscopy, subtalar joint, surgical; with debridement	090	9.65	<b>0.066</b>	244	40	15	10	60	15	0.5	3	1
1997 MPC	<b>29891</b>	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	090	9.67	<b>0.069</b>	227	50			60	25		4	
2005 MPC	<b>50590</b>	Lithotripsy, extracorporeal shock wave	090	9.77	<b>0.080</b>	234	35	15	13	60	30	0.5	2	1
2005	<b>67902</b>	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling	090	9.82	<b>0.074</b>	221	10	10	13	78	20	0.5	1	3

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

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTR	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
		(includes obtaining fascia)												
1997 MPC	<b>53850</b>	Transurethral destruction of prostate tissue; by microwave thermotherapy	090	10.08	<b>0.064</b>	<b>241</b>	60			<b>90</b>	45		2	
2007	<b>19301</b>	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	090	10.13	<b>0.093</b>	<b>216</b>	30	10	15	<b>60</b>	20	0.5	2	1

The RUC reaffirms its recommendation of 9.16 for CPT Code 64831.

#### February 2008 RUC Recommendations

CPT code 64831 *Suture of digital nerve, hand or foot; one nerve*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU is misvalued, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU are necessary. Based on the specialty society survey, the RUC agreed that the survey median time was appropriate. The recommended physician times are pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 10, intra-service = 60, and immediate post-service = 15. Further, the specialty recommended and the RUC agreed that the changes in office and hospital visits based on the survey be adjusted to the work RVU, using a building block method. The survey data showed that four office visits including two 99212 and two 99213 were associated with this service. The specialty also recommended one-half 99238 discharge day management visit. To find an appropriate value, the specialty society reduced the current work RVU, to account for the removal of one-half 99238 (0.64 work RVUs), one 99231 (0.76 work RVUs), and one-half 99213 (0.46 work RVUs). This accounted for a total reduction in work RVU of 1.86. The specialty then added the work associated with two 99212 (0.90 work RVUs). The resulting value is 9.27, which the RUC agreed was too high, considering the survey results. The RUC agreed that the surveyed 25<sup>th</sup> percentile RVU of 9.00 was more appropriate. The RUC referred to the key reference service, 64910, Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve, (work RVU = 11.21). The key reference service has slightly less pre-service time (50 minutes and 65 minutes, respectively), but considerably more intra-service time (90 minutes and 60 minutes, respectively). However, survey respondents indicated that the intensity and complexity of the services are very similar. The RUC further validated the 25<sup>th</sup> percentile RVU by calculating the IWPUT for both the surveyed code (0.06738) and the key reference service (0.06674) and found that they were very similar. The RUC recommends the survey 25<sup>th</sup> percentile work RVU of 9.00 (9.16 in 2010).

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
64831	Suture of digital nerve, hand or foot; one nerve	090	9.16 (No change)

August 16, 2010

Barbara Levy, MD  
Chair, AMA/Multi-specialty Relative Value Update (RUC) Committee  
American Medical Association  
515 N. State St.  
Chicago, IL 60610

RE: Tab 70-64831, Neuropathy, Finger

Dear Dr. Levy,

In the Proposed Rule for the 2011 Medicare Physician Payment Schedule, CMS requested that the RUC "re-review" the RUC recommendations for existing CPT codes, originally identified as site-of-service anomalies. The RUC requested that each specialty society prepare a letter and supporting documents explaining why the listed codes are appropriately valued and explain why the methodology described by CMS would not result in a substantially different work RVU from the previously submitted RUC recommendation.

In January of 2008, the American Academy of Orthopaedic Surgery, the American Society for Surgery of the Hand, and the American Society of Plastic Surgeons conducted a standard RUC survey for code 64831 Suture of digital nerve, hand or foot; 1 nerve, and presented the survey results at the January 2008 RUC meeting. This was in response to a "site-of-service" anomaly based on the CMS data indicating more than 50% of the procedures were being discharged from outpatient facilities while the value included inpatient facility visits. We collected 73 total responses (for a code performed less than 1,000 in the Medicare population) and recommended a 12% decrease in work RVUs from 10.23 to 9.00 work RVUs, the survey 25<sup>th</sup> percentile. Our recommendation was based on magnitude estimation comparing 64831 to key reference code of 64910 Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve. The RUC also agreed with our argument that physician work that would have been provided in the facility must now be provided in the office, but that the total work would be slightly less. This is reflected in the 12% decrease recommended for the code. All of this was based on magnitude estimation.

In comparing 64831 to 64910, we noted the intra-times of the two codes were different, with our survey median intra-time equaling 60 minutes compared to the intra-time of 90 minutes for 64910. However, 64910 had a total value at the time of 11.21, or 2.21 RVW greater than our recommended value. When you compared the IPUT for both codes, they were both 0.067, thus keeping rank order between these two codes. We felt this made the 25<sup>th</sup> percentile RVW recommended by our surveyees a very reasonable comparative value.

At this time, we would like to present additional information to support the current work RVU. During the Harvard study of 64831, only estimates for time were captured and then multiplied by assigned intensities to calculate total work, which was then transformed to work relative value units (ie, the building block methodology, as used by Harvard). Number and level of hospital and/or office visits were imputed by a CMS contractor for purposes of reviewing practice expense RVUs many years after completion of the Harvard study. Additionally, we also note that for many of the codes, pre- and post-time was predicted using an algorithm that took into account the surveyed intra-

service time and the pre- and post-times of an anchor code. Given this information, it should be clear that work RVUs for visits in current survey data should not be added and/or subtracted from the work RVU for 64831 because time, not visits, was used as building blocks to calculate the initial work RVU.

We disagree with the methodology that CMS describes as "reverse building block". The methodology described is flawed in that it compares apples (Harvard minutes) to oranges (imputed E/M visits). It is no wonder that the Agency's calculations for some codes result in negative work, since the Agency was mixing data elements incorrectly. The building block for 64831 involved time and assigned intensities followed by technical expert group review that did not include some of the now dominant providers and then CMS refinement panels as necessary through magnitude estimation. The RUC's review of 64831, also utilized magnitude estimation to determine whether the recommended value for the code was supported. We also note that the Agency's flawed methodology results in a difference of (-0.13) work RVUs for 64831 from the RUC recommendation. For 20 years, peer-review and CMS refinement of codes has never resulted in such a minor incremental adjustment based on a calculation.

In addition to the key reference code 64910, which is an excellent comparison for 64831, we present a table of codes on the following page that includes MPC codes, high volume codes and/or recently RUC-reviewed codes that have the same intra-time, similar total time, and/or similar IWPUT. We believe a review – by magnitude estimation – of this list of procedures adds further support that the current work RVU for 64831 is not over-valued, as CMS suggests.

Sincerely,

William Creevy, MD  
Advisor, American Academy of Orthopaedic Surgery

Daniel Nagle, MD  
Advisor, American Society for Surgery of the Hand

Martha Mathews, MD  
Advisor, American Society of Plastic Surgeons

CC: RUC 5-Year ID Workgroup

**RUC-Reviewed Comparison Codes to Support the Current Work RVU of Code 64831**

RUC Review	CPT	LONG DESCRIPTOR	GLOB	RVW	IWPUT	TOT Time	PRE			INTRa	POST			
							eval	posit	s,d,w		sd-im	99238	99213	99212
2008	<b>45171</b>	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	090	8.13	<b>0.076</b>	209	33	15	15	<b>45</b>	20	0.5	2	1
2005	<b>37722</b>	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	090	8.16	<b>0.074</b>	198	40	10	10	<b>60</b>	20	0.5	1	1
2000 MPC	<b>43269</b>	Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent	000	8.20	<b>0.093</b>	141	40			<b>71</b>	30			
2000	<b>38530</b>	Biopsy or excision of lymph node(s); open, internal mammary node(s)	090	8.34	<b>0.063</b>	206	45			<b>73</b>	30	0.5	1	1
2008	<b>54530</b>	Orchiectomy, radical, for tumor; inguinal approach	090	8.46	<b>0.060</b>	247	58	10	15	<b>60</b>	30	0.5	1	2
2005	<b>37184</b>	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	000	8.66	<b>0.080</b>	160	20	10	10	<b>90</b>	30			
2001	<b>25275</b>	Repair, tendon sheath, extensor, forearm and/or wrist, with free graft (includes obtaining graft) (eg, for extensor carpi ulnaris subluxation)	090	8.96	<b>0.064</b>	223	40			<b>70</b>	23	0.5	1	3
2001	<b>29824</b>	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)	090	8.98	<b>0.065</b>	225	48			<b>60</b>	20	0.5	2	2
2008	<b>37761</b>	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	090	9.13	<b>0.074</b>	224	33	10	15	<b>60</b>	25	0.5	2	1
2007	<b>50593</b>	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	010	9.13	<b>0.064</b>	217	45	10	10	<b>90</b>	20	0.5	1	
2008	<b>64831</b>	Suture of digital nerve, hand or foot; 1 nerve	090	9.16	<b>0.067</b>	237	40	10	15	<b>60</b>	15	0.5	2	2
2008 MPC	<b>14060</b>	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips, defect 10 sq cm or less	090	9.23	<b>0.090</b>	183	15	10	5	<b>60</b>	15		2	2
2008	<b>23415</b>	Coracoacromial ligament release, with or without acromioplasty	090	9.23	<b>0.065</b>	247	40	15	15	<b>60</b>	20	0.5	2	2
2000	<b>49555</b>	Repair recurrent femoral hernia, reducible	090	9.39	<b>0.066</b>	218	45			<b>85</b>	30	0.5	1	1
2007	<b>29906</b>	Arthroscopy, subtalar joint, surgical; with debridement	090	9.65	<b>0.066</b>	244	40	15	10	<b>60</b>	15	0.5	3	1
1997 MPC	<b>29891</b>	Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect	090	9.67	<b>0.069</b>	227	50			<b>60</b>	25		4	
2005 MPC	<b>50590</b>	Lithotripsy, extracorporeal shock wave	090	9.77	<b>0.080</b>	234	35	15	13	<b>60</b>	30	0.5	2	1
2005	<b>67902</b>	Repair of blepharoptosis, frontalis muscle technique with autologous fascial sling (includes obtaining fascia)	090	9.82	<b>0.074</b>	221	10	10	13	<b>78</b>	20	0.5	1	3
1997 MPC	<b>53850</b>	Transurethral destruction of prostate tissue; by microwave thermotherapy	090	10.08	<b>0.064</b>	241	60			<b>90</b>	45		2	
2007	<b>19301</b>	Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy);	090	10.13	<b>0.093</b>	216	30	10	15	<b>60</b>	20	0.5	2	1

Tables 15 &amp; 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review

CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	9911	9919	9923	9924	9929	9931	9932	9933	9935	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75	10	15		75	120	43	2	2	2		1	1	1	1	428	0.0145		Pre-RUC Evaluation	
		10.03	2010	1,123	60			85	90	30		2	2							283	0.0530	AAOMS	Post-RUC Evaluation
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49	10	15		49	62	23	3.5			0.5		1	1	1	238	0.0866		Pre-RUC Evaluation	
		9.23	2010	1,237	40			70	60	20	2.0	2.0							0.5	247	0.0648	AAOS	Post-RUC Evaluation
		7.38	2009		36			36	78	21	5.0			1.5		1.0	1.0	1.0	283	0.0192		Pre-RUC Evaluation	
25116	REMOVE WRIST/FOREARM LESION	7.56	2010	1,030	40	10	15	65	60	20	1.0	3.0							0.5	249	0.0307	ASSH, AAOS, ASPS	Post-RUC Evaluation
		7.91	2007		21	25			83	19	4.0		1.5			1.0							Pre-RUC Evaluation
27792	TREATMENT OF ANKLE FRACTURE	9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0	1.0		1.0	1.0	1.0	1.0	281	0.0513	AAOS, AOFAS	Post-RUC Evaluation	
		5.64	2009		47			47	67	21	3.5		1.5			1.0	1.0	1.0	259	0.0056		Pre-RUC Evaluation	
28120	PART REMOVAL OF ANKLE/HEEL	8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0	1.0		1.0	1.0	1.0	1.0	280	0.0263	AAOS, APMA	Post-RUC Evaluation	
		7.56	2009		43			43	51	26	5.0		1.5			1.0	1.0	1.0	268	0.0304		Pre-RUC Evaluation	
28122	PARTIAL REMOVAL OF FOOT BONE	7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0	1.0		1.0	1.0	1.0	1.0	264	0.0249	AAOS, APMA	Post-RUC Evaluation	
		11.97	2009		50			50	89	22	4.0		2.5			1.0	1.0	1.0	313	0.0631		Pre-RUC Evaluation	
28725	FUSION OF FOOT BONES	12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0		1.0	1.0	1.0	1.0	339	0.0496	AAOS, AOFAS, APMA	Post-RUC Evaluation	
		12.21	2009		60				60	120			5.0		1.0		1.0	1.0	383	0.0331		Pre-RUC Evaluation	
28730	FUSION OF FOOT BONES	12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0		1.0	1.0	1.0	1.0	349	0.0471	AAOS, AOFAS, APMA	Post-RUC Evaluation	
		3.71	2008		17			25	42	36	16	3.5		0.5		1.0	1.0	1.0	198	0.0151		Pre-RUC Evaluation	
28825	PARTIAL AMPUTATION OF TOE	6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0				1.0	1.0	1.0	224	0.0099	AAOS	Post-RUC Evaluation	
		9.15	2008		29			25	54	75	28	2.5	1.5			1.0	1.0	1.0	265	0.0540		Pre-RUC Evaluation	
36821	AV FUSION DIRECT ANY SITE	12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0				1.0	1.0	1.0	256	0.0823	ACS, SVS, RPA	Post-RUC Evaluation	
		10.00	2009		56			56	81	22	2.5		1.0			1.0	1.0	1.0	257	0.0663		Pre-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAFT	15.13	2010	4,873	40	10	20	70	120	30	1.0	2.0	1.0		1.0	1.0	1.0	1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation	
		17.99	2009		55			55	156	37	3.5	1.5				1.0	1.0	1.0	396.5	0.0671		Pre-RUC Evaluation	
42415	EXCISE PARTOID GLAD/LESION	18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0				1.0	1.0	1.0	342	0.0843	ACS, AAO-HNS	Post-RUC Evaluation	
		20.87	2009		57			57	182	22	3.5	3.0				1.0	1.0	1.0	439.5	0.0687		Pre-RUC Evaluation	
42420	EXCISE PARTOID GLAD/LESION	21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0	1.0		1.0	1.0	1.0	1.0	432	0.0743	ACS, AAO-HNS	Post-RUC Evaluation	
		7.05	2009		47			47	71	19	1.5		0.5			1.0	1.0	1.0	209	0.0500		Pre-RUC Evaluation	
42440	EXCISE SUBMAXILLARY GLAND	7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0				0.5	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation			
		9.97	2009		45				45	67.5	30	1.0	1.0				1.0	1.0	1.0	239.5	0.0714		Pre-RUC Evaluation
49507	PRP I/HERN INIT BLOCK >5 YR	10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0				1.0	1.0	1.0	260	0.0680	ACS	Post-RUC Evaluation	
		12.36	2009		45			45	90	30	1.0	1.0				1.0	1.0	1.0	262	0.0799		Pre-RUC Evaluation	
49521	REREPAIR ING HERNIA, BLOCKED	12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0				1.0	1.0	1.0	280	0.0795	ACS	Post-RUC Evaluation	
		7.96	2009		45			45	60	30	1.0	1.0				1.0	1.0	1.0	232	0.0465		Pre-RUC Evaluation	
49587	RPR UNBIL HERN, BLOCK >5 YR	8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0				1.0	1.0	1.0	250	0.0459	ACS	Post-RUC Evaluation	
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010		45	15	15	75	90	30	1.0	1.0				1.0	1.0	1.0	292	0.0806	ACS	New Code in 2009	
49653	LAP VENT/ABD HERN PROC COMP	16.21	2010		45	15	15	75	120	30	2.0	1.0				1.0	1.0	1.0	378	0.0726	ACS	New Code in 2009	
49654	LAP INC HERNIA REPAIR	15.03	2010		45	15	15	75	120	30	1.0	1.0				1.0	1.0	1.0	362	0.0668	ACS	New Code in 2009	
49655	LAP INC HERN REPAIR COMP	18.11	2010		50	15	15	80	150	30	2.0	1.0				1.0	1.0	1.0	413	0.0700	ACS	New Code in 2009	
		6.11	2008		47.5			47.5	60	49									156.5	0.0658		Pre-RUC Evaluation	
52341	CYSTO W/URETER STRICTURE TX	5.35	2010	2,105	45	10	15	70	45	20									135	0.0789	AUA	Post-RUC Evaluation	
		6.61	2008		60			60	65	30									175	0.0590		Pre-RUC Evaluation	
52342	CYSTO W/UP STRICTURE TX	5.85	2010	281	40	10	10	60	60	20									140	0.0700	AUA	Post-RUC Evaluation	
		7.31	2008		60			60	90	30									200	0.0504		Pre-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	6.55	2010	37	45	10	10	65	60	25									150	0.0780	AUA	Post-RUC Evaluation	
		7.81	2008		60			60	77.5	30									187.5	0.0650		Pre-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.05	2010	2,447	40	10	10	60	45	20									125	0.1200	AUA	Post-RUC Evaluation	
		8.31	2008		50			50	90	30									190	0.0640		Pre-RUC Evaluation	
52345	CYSTO/URETERO W/UP STRICTURE	7.55	2010	475	45	10	15	70	45	20									135	0.1277	AUA	Post-RUC Evaluation	
		9.34	2008		45			45	120	49									214	0.0603		Pre-RUC Evaluation	
52346	CYSTOURERETO W/RENAL STRICT	8.58	2010	144	40	10	10	60	60	20									140	0.1155	AUA	Post-RUC Evaluation	
		10.06	2008		90			90	60	30									126	0.0727		Pre-RUC Evaluation	
52400	CYSTOURERETO W/CONGEN REPR	8.69	2010	635	72.5	10	15	97.5	40	25									0.5	197.5	0.1260	AUA	Post-RUC Evaluation
		9.39	2008		40			40	45	35									10	247	0.0613		Pre-RUC Evaluation
52500	REVISION OF BLADDER NECK	8.14	2010	5,348	45	10	15	70	45	27.5									0.5	230.5	0.0582	AUA	Post-RUC Evaluation
		6.89	2008		50			50	39	17	20								10	216	0.0509		Pre-RUC Evaluation
52640	RELIEVE BLAD CONTRA TURE	4.79	2010	2,217	40	10	10	60	30	20									0.5	161	0.0514	AUA	RUC Evaluation

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CPT Code		Short Descriptor	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99215	99232	99233	99238	Total Time	IWPUT	Specialty Societies	Review	
			15.21	2009	75			75	126	24		3.0		3.0		1.0	1.0	1.0	392	0.0546	Pre-RUC Evaluation		
53445	INSERT URO/VES NCK SPHINCTER		15.39	2010	1,949	50	15	20	85	90	25	1.0	3.0		1.0	1.0	1.0	418	0.0572	AUA	Post-RUC Evaluation		
			16.48	2008	50			50	145	30		2.0	1.0	1.0				1.0	369	0.0635	Pre-RUC Evaluation		
54410	REMOVE/REPLACE PENIS PROSTH		15.18	2010	1,328	40	10	15	65	120	30	1.0	3.0					1.0	338	0.0716	AUA	Post-RUC Evaluation	
			9.31	2008	58			58	58	17		2.5		0.5		1.0	1.0	1.0	238.5	0.0673	Pre-RUC Evaluation		
54530	REMOVAL OF TESTIS		8.46	2010	1,426	57.5	10	15	82.5	60	30	2.0	1.0			0.5	1.0	1.0	246.5	0.0597	AUA	Post-RUC Evaluation	
			11.49	2008	45			45	70	30		1.0	2.0	2.0		1.0	1.0	1.0	285	0.0656	Pre-RUC Evaluation		
57287	REVISE/REMOVE SLING REPAIR		11.15	2010	1,795	40	10	10	60	60	20	1.0	3.0	1.0	1.0	1.0	1.0	1.0	244	0.0912	AUA, ACOG	Post-RUC Evaluation	
			7.37	2009	50			50	50	25		1.0	1.0	1.0		1.0	1.0	1.0	325	0.027	Pre-RUC Evaluation		
61885	INSRT/REDO NEUROSTIM I ARRAY		6.44	2010	4,358	33	3	15	51	45	20		2.0				0.5	1.0	1.0	181	0.0567	AANS/CNS	Post-RUC Evaluation
			6.41	2009	40			40	30	20		2.0		2.0		1.0	1.0	1.0	200	0.0435	Pre-RUC Evaluation		
62263	EPIDURAL LYSIS MULT SESSIONS		6.54	2010	1,269	33	10	5	48	45	20	1.0	2.0				0.5	1.0	1.0	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation
			8.04	2008	70			70	60	125		4.0		1.0	1.0	2.0	1.0	1.0	487	-0.0715	Pre-RUC Evaluation		
62350	IMPLANT SPINAL CANAL CATH		6.05	2010	6,416	33	10	5	48	60	20		1.0				0.5	1.0	1.0	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation
			6.60	2008	60			60	40	130		3.0		1.0		1.0	2.0	1.0	446	-0.1284	Pre-RUC Evaluation		
62355	REMOVE SPINAL CANAL CATHETER		4.35	2010	1,461	33	10	5	48	30	20		1.0				0.5	1.0	1.0	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation
			3.68	2008	60			60	55	123		4.0				2.0	1.0	1.0	450	-0.1385	AAPMR, ASA, NASS, AAPM, AANS/CNS	Pre-RUC Evaluation	
62360	INSERT SPINE INFUSION DEVICE		4.33	2010	616	33	10	5	48	60	20		1.0				0.5	1.0	1.0	170	0.0211	AAPM, AANS/CNS	Post-RUC Evaluation
			6.59	2008	60			60	60	130		4.0		1.0		1.0	2.0	1.0	482	-0.0938	AAPM, AANS/CNS, ASA, ISIS, NASS	Pre-RUC Evaluation	
62361	IMPLANT SPINE INFUSION PUMP		5.65	2010	307	33	10	5	48	60	20		1.0				0.5	1.0	1.0	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation
			8.58	2008	75			75	90	150		4.0				3.0	1.0	1.0	582	-0.0629	Pre-RUC Evaluation		
62362	IMPLANT SPINE INFUSION PUMP		6.10	2010	6,570	33	10	5	48	60	20		1.0				0.5	1.0	1.0	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation
			6.57	2008	60			60	45	125		3.0		1.0		1.0	2.0	1.0	446	-0.1123	Pre-RUC Evaluation		
62365	REMOVE SPONE INFUSION DEVICE		4.65	2010	1,598	33	10	5	48	45	20		1.0				0.5	1.0	1.0	155	0.0353	AAPM, AANS/CNS	Post-RUC Evaluation
			7.57	2008	56			56	74	19		2.0		2.5		1.0	1.0	1.0	283	0.0152	AAPM, AANS/CNS, ASA, ISIS, NASS	Pre-RUC Evaluation	
63650	IMPLANT NEUROELECTRODES		7.20	2010	31,144	33	10	5	48	60	20		1.0				0.5	1.0	1.0	170	0.0690	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation
			7.87	2008	53			53	62	18		2.0		2.5		1.0	1.0	1.0	267	0.0245	AAPM, AANS/CNS, NASS, ASA, ISIS	Pre-RUC Evaluation	
63685	INSRT/REDO SPINE N GENERATOR		6.05	2010	9,343	33	10	5	48	60	20		1.0				0.5	1.0	1.0	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation
			6.22	2009	46			46	76	18		2.5		0.5		1.0	1.0	1.0	228	0.0301	Pre-RUC Evaluation		
64708	REVISE ARM/LEG NERVE		6.36	2010	3,069	35	10	10	55	60	15		3.0	1.0			0.5	1.0	1.0	220	0.0314	AOFS, ASSH, AAOS, ASPS	Post-RUC Evaluation
			10.23	2008	50			50	74	21		2.5		1.0		1.0	1.0	1.0	260.5	0.0612	AAOS, ASPS, ASSH	Pre-RUC Evaluation	
64831	REPAIR OF DIGIT NERVE		9.16	2010	972	40	10	15	65	60	15		2.0	2.0			0.5	1.0	1.0	237	0.0674	AOFS, ASSH, AAOS, ASPS	Post-RUC Evaluation
			14.43	2009	52			52	79	32		5.5	0.5			1.0	1.0	1.0	337.5	0.0730	Pre-RUC Evaluation		
65285	REPAIR OF EYE WOUND		14.71	2010	1,154	37		15	52	79	32		5.5	0.5			1.0	1.0	1.0	337.5	0.0766	AAO	Post-RUC Evaluation

Codes to be reviewed on the Fourth Five-Year Review Agenda (5264D and 57287) and recent May 2010 Submission (61883)

23+ Hour Services to be reviewed in February 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values.

2010 Post- RUC Review work RVWs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10

threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premaig les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
11179 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC-recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min .....	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs).	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min .....	90 min .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0 0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	- 0.44 RVUs	0.38 RVUs ...	- 0.76 RVUs	- 1.39 RVUs	- 0.64 RVUs	- 0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39)$

$$- 0.64 - 0.36 = 8.08$$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insrt/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup>We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insrt/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup>We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IWPOT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IWPOT is counterintuitive to the IWPOT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2008

**Neurorrhaphy-Finger**

CPT code 64831, *Suture of digital nerve, hand or foot; one nerve*, was identified by the RUC's Five-Year Review Identification Workgroup as a site of service anomaly utilizing information from the current physician time data and the Medicare claims data. The physician time data for this code currently includes hospital visits and discharge management services, however, the Medicare claims data indicate that the service is typically performed in an outpatient setting. CMS agreed with the RUC that this service should be evaluated.

The specialty society presenters agreed that the site of service for this code has shifted from predominantly inpatient to outpatient. The presenters did not agree that the current work RVU was incorrect, but did agree that the current time and post-service hospital and office visits were no longer accurate and appropriate adjustments to the work RVU are necessary. Based on the specialty society survey, the RUC agreed that the survey median time was appropriate. The recommended physician times are pre-service evaluation = 40, pre-service scrub, dress and wait = 15, pre-service positioning = 10, intra-service = 60, and immediate post-service = 15. Further, the specialty recommended and the RUC agreed that the changes in office and hospital visits based on the survey be adjusted to the work RVU, using a building block method. The survey data showed that four office visits including two 99212 and two 99213 were associated with this service. The specialty also recommended one-half 99238 discharge day management visit. To find an appropriate value, the specialty society reduced the current work RVU, assumed to be correct, to account for the removal of one-half 99238 (0.64 work RVUs), one 99231 (0.76 work RVUs), and one-half 99213 (0.46 work RVUs). This accounted for a total reduction in work RVU of 1.86. The specialty then added the work associated with two 99212 (0.90 work RVUs). The resulting value is 9.27, which the RUC agreed was too high, considering the survey results. The RUC agreed that the surveyed 25<sup>th</sup> percentile RVU of 9.00 was more appropriate. The RUC referred to the key reference service, 64910, Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve, (work RVU = 11.21). The key reference service has slightly less pre-service time (50 minutes and 65 minutes, respectively), but considerably more intra-service time (90 minutes and 60 minutes, respectively). However, survey respondents indicated that the intensity and complexity of the services are very similar. The RUC further validated the 25<sup>th</sup> percentile RVU by calculating the IPUT for both the surveyed code (0.06738) and the key reference service (0.06674) and found that they were very similar. **The RUC recommends the survey 25<sup>th</sup> percentile work RVU of 9.00.**

**Practice Expense**

The RUC recommends an adjustment in the direct practice expense inputs for these codes to reflect any change in office visits associated with this service.

CPT Code (•New)	CPT Descriptor	Global Period	Work RVU Recommendation
64831	Suture of digital nerve, hand or foot; one nerve	090	9.00

**AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS**  
**SUMMARY OF RECOMMENDATION**

---

CPT Code: 64831      Tracking Number  
 Global Period: 090

Specialty Society Recommended RVU: **9.00**  
 RUC Recommended RVU: **9.00**

CPT Descriptor: Suture of digital nerve, hand or foot; one nerve

**CLINICAL DESCRIPTION OF SERVICE:**

- Vignette Used in Survey: A 25-year-old woman, who lacerated the ulnar digital nerve of the thumb while cutting a bagel, undergoes repair of the ulnar digital nerve of the thumb. [Note, if performed, microsurgical techniques, would be reported separately.]

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

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No Percent of survey respondents who stated it is typical in the Hospital/ASC setting? 0%

Is moderate sedation inherent to this procedure in the office setting? No Percent of survey respondents who stated it is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

**Description of Pre-Service Work:**

- Select and order the appropriate antibiotic(s) and confirm timing and administration.
- Review results of preadmission testing including labs, X-rays, CT scans, and/or MRIs.
- Perform 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.
- Scrub and gown.
- The arm is draped.
- The arm is elevated and exsanguinated.
- The pneumatic tourniquet is inflated.
- Perform surgical "time out" with operating surgical team

**Description of Intra-Service Work:** The lacerated digital nerve is exposed through a Bruner incision. The subcutaneous tissue is carefully dissected to expose the nerve. Great care is taken to protect the adjacent digital artery and flexor tendon. The nerve is cleared of any scar tissue and the lacerated ends of the nerve are freshened as needed. An epineurial nerve repair is performed. The tourniquet is deflated. Meticulous hemostasis is achieved. The skin closed

**Description of Post-Service Work:**

Post-service work: in facility

- Application of bulky dressing, reinforced with long arm splint

- Monitor 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.
- Dictation of an operative report
- Procedure note is written in the patient chart
- All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

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**

<b>RUC Meeting Date (mm/yyyy)</b>	02/2008				
<b>Presenter(s):</b>	Daniel Nagle, MD, FACS; Dale Blasier, MD, FACS; Scott Oates, MD				
<b>Specialty(s):</b>	ASSH, AAOS, ASPS: American Society for Surgery of the Hand; American Academy of Orthopaedic Surgery; American Society of Plastic Surgeons				
<b>CPT Code:</b>	64831				
<b>Sample Size:</b> 200	<b>Resp N:</b> 73	<b>Response:</b> 36.5 %			
<b>Sample Type:</b> Random					
		<u>Low</u>	<u>25<sup>th</sup> pctl</u>	<u>Median*</u>	<u>75<sup>th</sup> pctl</u>
<b>Service Performance Rate</b>		0.00	5.00	<b>10.00</b>	15.00
<b>Survey RVW:</b>		6.20	9.00	<b>10.50</b>	11.21
<b>Pre-Service Evaluation Time:</b>				<b>40.0</b>	
<b>Pre-Service Positioning Time:</b>				<b>10.0</b>	
<b>Pre-Service Scrub, Dress, Wait Time:</b>				<b>15.0</b>	
<b>Intra-Service Time:</b>		20.00	45.00	<b>60.00</b>	60.00
<b>Immediate Post Service-Time:</b>	<b>15.00</b>				
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>			
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0	99292x 0.0		
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0	99232x 0.0	99233x 0.0	
<b>Discharge Day Mgmt:</b>	<b>19.0</b>	99238x 0.50	99239x 0.00		
<b>Office time/visit(s):</b>	<b>78.0</b>	99211x 0.0	12x 2.0	13x 2.0	14x 0.0
<b>Prolonged Services:</b>	<b>0.0</b>	55x 0.0	56x 0.0	57x 0.0	

\*\*Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

**SPECIALTY SOCIETY RECOMMENDED DATA**

Check here  if the specialty society recommended data is the same as survey data (Median Base Unit Value and Time). Do not tab through the following table - proceed to the new technology/service box.

However, if your society's recommendation is different than the survey data, enter your recommendation in the following table, and tab through to the new technology/service box.

<b>CPT Code:</b> 64831		
		<u>Specialty Recommended</u>
<b>Physician Work RVU:</b>		<b>9.00</b>
<b>Pre-Service Evaluation Time:</b>		<b>40.0</b>
<b>Pre-Service Positioning Time:</b>		<b>10.0</b>
<b>Pre-Service Scrub, Dress, Wait Time:</b>		<b>15.0</b>
<b>Intra-Service Time:</b>		<b>60.00</b>
<b>Immediate Post Service-Time:</b>	<b>15.00</b>	
<b>Post Operative Visits</b>	<b>Total Min**</b>	<b>CPT Code and Number of Visits</b>
<b>Critical Care time/visit(s):</b>	<b>0.0</b>	99291x 0.0
<b>Other Hospital time/visit(s):</b>	<b>0.0</b>	99231x 0.0
<b>Discharge Day Mgmt:</b>	<b>19.0</b>	99238x 0.5
<b>Office time/visit(s):</b>	<b>78.0</b>	99211x 0.0
<b>Prolonged Services:</b>	<b>0.0</b>	55x 0.0

**Modifier -51 Exempt Status**

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

**New Technology/Service:**

Is this new/revised procedure considered to be a new technology or service? No

**KEY REFERENCE SERVICE:**

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64910	090	11.21	RUC Time

CPT Descriptor Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve

**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
67904	090	57,702	7.83		

CPT Descriptor 1 Repair of blepharoptosis; (tarsal) levator resection or advancement, external approach

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Most Recent</u>		<u>Work RVU</u>	<u>Time Source</u>
		<u>Medicare Utilization</u>	<u>RUC Time</u>		
50590	090	54,274	9.64		

CPT Descriptor 2 Lithotripsy, extracorporeal shock wave

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>

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: 49.3 %

<u>TIME ESTIMATES (Median)</u>	<u>CPT Code:</u> <u>64831</u>	<u>Key Reference CPT Code:</u> <u>64910</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	65.00	50.00	
Median Intra-Service Time	60.00	90.00	
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	19.0	19.00	
Median Office Visit Time	78.0	85.00	
Prolonged Services Time	0.0	0.00	
<b>Median Total Time</b>	<b>237.00</b>	<b>264.00</b>	

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	2.78	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.69	2.85
--	------	------

Urgency of medical decision making	3.28	3.06
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#### **Technical Skill/Physical Effort (Mean)**

Technical skill required	4.22	4.24
--------------------------	------	------

Physical effort required	3.47	3.53
--------------------------	------	------

#### **Psychological Stress (Mean)**

The risk of significant complications, morbidity and/or mortality	3.14	3.21
---	------	------

Outcome depends on the skill and judgment of physician	4.08	4.15
--	------	------

Estimated risk of malpractice suit with poor outcome	3.03	3.03
--	------	------

### INTENSITY/COMPLEXITY MEASURES

### CPT Code

### Reference Service 1

#### **Time Segments (Mean)**

Pre-Service intensity/complexity	2.94	3.12
----------------------------------	------	------

Intra-Service intensity/complexity	3.77	3.82
------------------------------------	------	------

Post-Service intensity/complexity	2.91	2.91
-----------------------------------	------	------

### **Additional Rationale**

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

Current data for 64831 is based on a Harvard survey of 6 neurosurgeons. The current Harvard-based RVW (10.23) and Harvard data result in an IPUT = 0.063.

Our expert consensus panel carefully reviewed the survey data for 64831 and believe there is compelling evidence to review this service because of:

- 1) Flawed methodology used in the Harvard valuation because neurosurgeons were surveyed even though they are not significant providers of this service.

Code 64831 describes a procedure for suture of digital nerve, hand or foot, however, this procedure is typically reported for upper extremity work and rarely used for the foot. We surveyed general orthopaedic surgeons, plastic surgeons and hand surgeons (who represent more than 95 percent of all claims), using a vignette for the upper extremity.

Our expert consensus panel agrees with the median survey facility visit data that indicates the typical patient is discharged from a facility on the day of the procedure. This however does not mean that the post-operative office visits will remain unchanged compared with twenty years ago. The physician work that would have been provided in the facility must now be provided in the office thus explaining the need for two 99213 level post operative visits.

In comparison to the key reference code 64910 (Nerve repair; with synthetic conduit or vein allograft (eg, nerve tube), each nerve), the survey code 64831 is less total work. The survey median RVW and survey median time and visit data result in an IPUT that is inconsistent with similar procedures. The current value is very similar to the survey median, and also results in an IPUT that is inconsistent with similar procedures. **We recommend the survey 25<sup>th</sup> percentile RVW of 9.00 and survey median time and visit data.** This RVW (9.00) is less than the current RVW (10.23) and results in an IPUT = 0.067 which is the same intensity as the key reference service 64910. We also offer two MPC codes 67904 and 50590 with slightly lower and slightly higher RVWs.

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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.
- 

## FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64831

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)  
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopaedic surgery

How often? Sometimes

Specialty plastic surgery                    How often? Sometimes

Specialty hand surgery                    How often? Sometimes

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 the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency not available

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,239  
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare claims data

Specialty orthopaedic surgery	Frequency 500	Percentage 40.35 %
-------------------------------	---------------	--------------------

Specialty plastic surgery	Frequency 450	Percentage 36.31 %
---------------------------	---------------	--------------------

Specialty hand surgery	Frequency 225	Percentage 18.15 %
------------------------	---------------	--------------------

Do many physicians perform this service across the United States? Yes

---

### **Professional Liability Insurance Information (PLI)**

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? No

If no, please select another crosswalk and provide a brief rationale. 64831 - use current code

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

October 2010 – RUC Re-Review  
February 2008 – Initial Review

**Repair of Eye Wound**

**October 2010 RUC Re-Review**

In response to the CMS request to re-review CPT code 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue*, the RUC asked the specialty to provide additional rationale regarding the appropriateness of the current work RVU of 14.71. The specialty explained that the typical patient is a young trauma patient that is hospitalized. The RUC suggested that a CPT clarification to ensure that the code is reported appropriately (ie, not to report to repair a surgical wound) and that the specialty re-survey the clarified descriptor.

**The CPT Editorial Panel will clarify 65285 and the specialty will survey the service for the February 2011 RUC Meeting.**

**February 2008 RUC Recommendation**

The RUC had indicated that compelling evidence was necessary if the specialty believed the site of service should remain the same for a particular service, despite recent Medicare claims data. The specialty presented a recent journal article that described the service, its complexity, and necessity of being performed in the facility setting. The specialty explained that many of the services in the Medicare data are coding errors and that the service should be removed from the ambulatory service center listing because it requires an overnight hospital stay. The RUC agreed that the procedure is typically provided within the facility inpatient setting.

**The RUC agreed with the compelling evidence presented and recommends code 65285 be removed from the Site of Services Anomalies list and the physician time be reverted back to its original Harvard determined physician time. It was suggested by the specialty that this service not be included on the ASC list. In addition, a CPT Assistant article should be written to describe appropriate use of this code.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
65285	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue	090	14.71 (interim-no change) (Resurvey – Feb 2011)



August 5, 2010

Dr. Barbara Levy, Chair  
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Federal Affairs Department

Dear Dr. Levy:

The Academy is responding to the CMS request regarding site of service anomalies previously considered by the RUC. For ophthalmology, we have one code that was chosen by CMS requiring additional review. CMS has proposed a reduction in value because of a change in the site of service from inpatient to outpatient facilities. This code is 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue.*

**The Academy disagrees with the CMS suggestion that time or work be removed from this procedure to reflect a change in Site of Service. At the February 2008 meeting, the RUC agreed that the Academy has presented compelling information that supported our position that the Medicare data for this service are incorrect, because they do not capture the typical patient treated for this condition.**

Our presentation at the February 2008 RUC meeting provided evidence which demonstrated that this procedure is primarily an inpatient procedure performed on patients who are males between the ages of 16 and 40 who have suffered significant trauma to their ocular and orbital structures. An article published in *Ophthalmology 2008;115:202-209 (enclosed)* showed that the median age of patients with this type of injury was 34 years and 75 percent were male. The study further shows that reported for all 214 cases of eye trauma seen at the Johns Hopkins' Wilmer Ophthalmological Institute between 2001 and 2004 , ".... They noted

*" no open globe injury was treated with primary enucleation. Even in instances where most of the globe's contents, including the retina, were lost, all severely traumatized eyes underwent primary closure of the wound within 24 hours of arriving at the Wilmer Ophthalmological Institute. After repair, patients were admitted to and cared for in the Wilmer inpatient unit."*

The Academy believes that this study demonstrates a treatment plan that would be typical for similar patients throughout the United States.

Further evidence that this procedure is infrequently performed in the Medicare age group is found in the RUC database. Only 1,154 cases were reported in 2008. The service represents one of the more complex procedures performed by ophthalmologists, requiring

hospitalization for 1-2 days postoperatively for IV antibiotics and close observation because of the significant anatomical disruption associated with this type of injury.

A RUC survey performed in preparation for the February 2008 meeting confirmed the number of hospital days indicated in the Johns Hopkins study. The pre-service time for this procedure is longer than for most other ophthalmic procedures because there is more clinical material to be collected and reviewed. Consultation with other medical specialties may be required to plan the surgical procedure in these patients who frequently have other serious injuries. Pre-service scrub, dress and wait is time is also longer than that for a typical ophthalmology procedure because of the special precautions required for protection of the eye and induction of general anesthesia in a patient with an open globe. The Academy also indicated that the procedure has grown in complexity as surgical repair is undertaken for many eyes that were formerly enucleated as a primary procedure. The survey included a 99232 on day one, a 99238 on day 2 and 6 outpatient visits. The outpatient visits are 99213 as they require an examination of the anterior and posterior segments with pupillary dilation because of the substantial concern for the development of a retinal detachment.

Therefore, we respectfully disagree that work or time be subtracted from this service and the Academy suggests that our previously submitted RUC summary recommendation be reconsidered as part of the October 2010 meeting. We appreciate the opportunity to continue this dialogue regarding CPT 65285.

Sincerely,



Michael X. Repka, M.D.  
Secretary, Federal Affairs



Stephen A. Kamenetzky, M.D.  
RUC Advisory

# Vision Survival after Open Globe Injury Predicted by Classification and Regression Tree Analysis

G. W. Schmidt, MD, A. T. Broman, MA, H. B. Hindman, MD, Michael P. Grant, MD, PhD

**Objective:** To assist ophthalmologists in treating ocular trauma patients, this study developed and validated a prognostic model to predict vision survival after open globe injury.

**Design:** Retrospective cohort review.

**Participants:** Two hundred fourteen patients who sought treatment at the Wilmer Ophthalmological Institute with open globe injuries from January 1, 2001, through December 31, 2004, were part of the data set used to build the classification tree model. Then, to validate the classification tree, 51 patients were followed up with the goal to compare their actual visual outcome with the outcome predicted by the tree grown from the classification and regression tree analysis.

**Methods:** Binary recursive partitioning was used to construct a classification tree to predict visual outcome after open globe injury. The retrospective cohort treated for open globe injury from January 1, 2001, through December 31, 2004, was used to develop the prognostic tree and constitutes the training sample. A second independent sample of patient eyes seen from January 1, 2005, through October 15, 2005, was used to validate the prognostic tree.

**Main Outcome Measures:** Two main visual outcomes were assessed: vision survival (range, 20/20–light perception) and no vision (included no light perception, enucleation, and evisceration outcomes).

**Results:** A prognostic model for open globe injury outcome was constructed using 214 open globe injuries. Of 14 predictors determined to be associated with a no vision outcome in univariate analysis, presence of a relative afferent pupillary defect and poor initial visual acuity were the most predictive of complete loss of vision; presence of lid laceration and posterior wound location also predicted poor visual outcomes. In an independent cohort of 51 eyes, the prognostic model had 85.7% sensitivity to predict no vision correctly and 91.9% specificity to predict vision survival correctly.

**Conclusions:** The open globe injury prognostic model constructed in this study demonstrated excellent predictive accuracy and should be useful in counseling patients and making clinical decisions regarding open globe injury management. *Ophthalmology* 2008;115:202–209 © 2008 by the American Academy of Ophthalmology.

The National Academy of Sciences has called trauma the “neglected epidemic of modern society,”<sup>1</sup> and in 1980, the National Society to Prevent Blindness reported more than 2.4 million eye injuries per year in the United States.<sup>2</sup> More recent estimates on the rates of hospitalized ocular trauma in the United States range from 4.1 to 13.2 injuries per 100 000 persons per year.<sup>3–5</sup> Outside the United States, the annual incidence rate of hospitalization for eye injury is similar: 8.1 hospitalizations per 100 000 persons per year in Scotland,<sup>6</sup>

12.6 hospitalizations per 100 000 persons per year in Singapore,<sup>7</sup> and 15.2 hospitalizations per 100 000 persons per year in Sweden.<sup>8</sup>

Trauma can result in a wide spectrum of injury to the eye. Open globe injury, defined as a full-thickness wound of the eye wall,<sup>9</sup> represents vision-threatening ocular injury. Despite public health campaigns organized to prevent eye injury, open globe injuries unfortunately still occur far too frequently. Four studies of eye injuries have reported the incidence of open globe injuries to be 2 per 100 000 persons per year in Wisconsin,<sup>3</sup> 3.8 per 100 000 persons per year in Maryland,<sup>4</sup> 6 per 100 000 persons per year among men and 1.2 per 100 000 persons per year among women in Stockholm,<sup>8</sup> and 3.5 per 100 000 persons per year in Pennsylvania.<sup>10</sup> Estimates are a global incidence rate of 3.5 per 100 000 persons per year for open globe injuries, leading to approximately 203 000 open globe injuries per year worldwide.<sup>11</sup>

Previous studies have described various aspects of open globe ocular trauma, including demographics,<sup>12–14</sup> prognosis,

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tic variables, and the role of vitrectomy.<sup>15–18</sup> Factors that have been found to correlate significantly with visual outcome include age,<sup>19–21</sup> type or mechanism of injury,<sup>20,22–29</sup> initial visual acuity,<sup>19–22,24–26,30–35</sup> presence of a relative afferent papillary defect (rAPD),<sup>22,36</sup> extent of wound and size of open-globe injury,<sup>22,23,30,31,33,37,38</sup> location of open globe wound,<sup>15,21–26,29,31,39</sup> lens damage,<sup>21,22,26,30</sup> hyphema,<sup>30</sup> vitreous hemorrhage,<sup>15,22,24,26,29,30</sup> retinal detachment,<sup>15,16,24,33</sup> and presence and type of intraocular foreign body.<sup>15,35,37</sup>

Despite an improved understanding of factors predictive of poor outcome after open globe injury, only one model, the Ocular Trauma Scoring (OTS) system,<sup>40</sup> has been developed to provide prognostic information regarding final visual outcome after eye injury. The OTS is a point system that combines points for (1) initial visual acuity with points for ocular trauma variables including: (2) globe rupture, (3) endophthalmitis, (4) perforating injury, (5) retinal detachment, and (6) relative afferent pupillary defect. Kuhn et al<sup>40</sup> analyzed more than 2500 injuries from the United States and Hungarian eye injury registries before identifying these predictors. Unfortunately, no description of their statistical methods is found in the published literature, and the OTS has never been validated in a prospective study.

In this study, the authors retrospectively analyzed data from a cohort of patients with an open globe injury evaluated at the Wilmer Ophthalmological Institute and constructed a decision tree to predict visual outcome using a statistical method known as classification and regression tree (CART) analysis.<sup>41</sup> Compared with decisions based on clinical experience or expert opinion, CART analysis has the advantage of creating decision rules based on data, rather than speculation. A second separate cohort was followed up to validate and test the sensitivity and specificity of the tree grown by CART analysis.

## Patients and Methods

This study was performed under the supervision of the Johns Hopkins Medicine Institutional Review Board, and Institutional Review Board approval was obtained. A review of all patients who sought treatment at the Wilmer Ophthalmological Institute with open globe injuries from January 1, 2001, through December 31, 2004, was conducted. Cases were identified from the Wilmer operating room records. Inpatient and outpatient records were examined to determine patient demographics, previous ocular history, visual acuity on presentation, presence of an rAPD, the location and extent of the open globe injury, associated anterior and posterior segment injuries, and the presence of adnexal trauma including lid laceration and orbital fracture. Injuries were classified by mechanism according to Birmingham Eye Trauma Terminology<sup>9</sup> as rupture or laceration (Table 1).

Table 1. Terms and Definitions for Open Globe Injury from Birmingham Eye Trauma Terminology

Rupture open globe	Full-thickness wound of the eye wall caused by a blunt object
Laceration open globe	Full-thickness wound of the eye wall caused by a sharp object

In addition, details of the primary and subsequent surgical and nonsurgical interventions were recorded. Follow-up data, including most recent best-corrected visual acuity, postoperative course, and duration of follow-up, were documented. The authors hypothesized that gender, age, cause of injury, initial visual acuity, rAPD, wound mechanism (rupture or laceration), wound length, wound location, an intraocular foreign body, orbital fracture, lid laceration, retinal detachment, hyphema, vitreous hemorrhage, lens damage, and endophthalmitis would be the most informative predictors of ocular survival following open globe trauma.

Testing of visual acuity of the injured eye was performed at initial examination at distance using a Snellen acuity chart or at near distance using the Rosenbaum card. When possible, all testing was carried out with the patient's corrective lenses, with and without pinhole. If visual acuity improved with pinhole, then this was recorded as the visual acuity at initial examination. If visual acuity was worse than 20/400, counting fingers vision, detection of hand movements (HM), and light perception (LP) were assessed. Visual acuity of no light perception (NLP) was confirmed with a bright light source, such as the indirect ophthalmoscope, set at the highest intensity while the fellow eye was completely occluded. The presence of an rAPD was measured by the swinging flashlight test. Wound location was defined according to the Ocular Trauma Classification Group.<sup>42</sup> For open globe injuries, zone I injuries were confined to the cornea and limbus. Zone II injuries involved the anterior 5 mm of the sclera (not extending into the retina). Zone III injuries involved full-thickness scleral defects more posterior than 5 mm from the limbus. The cause of injury was based on the history and circumstances of the injury reported by the victim, and cause of injury was divided into 2 categories: assault- versus non-assault-related injuries. The presence of an orbital fracture was evaluated clinically in 100% of patients and by computed tomography in 76% of patients.

All initial ophthalmic examinations were performed by trained ophthalmology house staff, and findings were confirmed by the Assistant Chief of Service, a retina-fellowship-trained attending ophthalmologist. If a predictor could not be identified in the record, data were left incomplete and marked as missing. The absence or presence of a lid laceration, hyphema, lens damage, vitreous hemorrhage, retina detachment, intraocular foreign body, and endophthalmitis also were assessed at initial ophthalmic examination.

## Statistical Analysis

Age was left as a continuous variable, and all other variables were divided into presence or absence of the characteristic. Initial visual acuity was divided into 6 categories: acuity 20/40 or better, worse than 20/40 to 20/400, worse than 20/400 to counting fingers, HM, LP, and NLP, enucleation, or evisceration. The outcome—visual acuity measured at the last visit—was divided into 2 categories: ocular survival (with visual acuity ranging between 20/20 and LP) and no vision (including enucleation, evisceration, and NLP vision). For patients with open globe injuries in both eyes, 1 eye was selected at random to be part of the analysis.

A classification tree was grown using binary recursive partitioning to predict the visual outcome of patients with open globe injury. Recursive partitioning is a statistical tool used to separate a group into 2 subgroups, repeatedly, given some risk factors of interest. All possible splits of this type are considered, and the 1 that best separates the data into groups is chosen. The end points of this tree were categorical: ocular survival or no vision. The measure used in this study was the entropy, or information criterion, where  $P$  is the probability of being in response category  $k$  at node  $i$ , and were estimated by the proportions of subjects in each category at a particular node.<sup>43,44</sup> This analysis was performed

using the rpart package in R (version 2.2.1). The model was adjusted to avoid creating a tree that matched too closely the peculiarities of a particular data set, known as overfitting. The tree was validated internally using 10-fold cross-validation, used to estimate the best splits. In the case where the splitting variable had missing values, surrogate variables were used to send observations down a particular branch; these surrogate variables were chosen so as to have the highest agreement with the splitting variable. Equal misclassification costs were assumed.

All open globe injuries from January 1, 2001, through December 31, 2004, were part of the data set used to build the tree and constitute the training sample. The tree was then shrunk to determine its optimal size using 10-fold cross-validation and pruned to minimize overfitting. All covariates listed in Table 2 were used in the construction of the tree except for lens injury, which had a large proportion of missing values. A second sample of patient eyes was followed up from January 1, 2005, through October 15, 2005, to validate the tree that was grown. Fellow eyes that were not part of the training set were used in the validation sample as well. The validation sample was used to assess the sensitivity and specificity of the CART model.

A secondary analysis was performed where the outcome—final visual acuity—was split at a different cutpoint: minimal to severe vision loss (with final vision 20/400 or better) versus profound vision loss (with final vision worse than 20/400, including 20/500 to NLP, enucleation, and evisceration). The same 14 predictors were used in this CART model as in the primary analysis.

## Results

There were 221 patients who sought treatment with open globe injuries from January 1, 2001, to December 31, 2004. Among these, 3 patients had bilateral open globe injuries; 1 eye from these patients was chosen at random to be part of this study. There were 7 patients who did not have final visual acuity outcomes, and their data were excluded from this analysis.

The median age of this cohort was 34 years (interquartile range [IQR], 20–52 years), and 75% were men. Of the 221 patients with open globe injuries, 114 patients sustained ruptured open globes, 106 sustained lacerated globes, and 1 injury was undetermined. By decade, the greatest number of injuries occurred in 30- to 39-year-old patients ( $n = 48$ ; 22.1%). Intentional trauma (assault) was responsible for 46 (21.5%) open globe injuries. Median follow-up was 150 days (IQR, 43–369 days; range, 1–1371 days). The overall rate of a no vision outcome (enucleation, evisceration, or NLP vision) in the retrospective cohort treated from January 1, 2001, through December 31, 2004, was 56 (26.2%).

## Univariate Analysis

Most variables hypothesized to be associated with final visual outcome in fact were associated at the univariate level: worse initial acuity ( $P < 0.0001$ ), presence of rAPD (odds ratio [OR], 53.7;  $P < 0.0001$ ), rupture open globe (OR, 9.0;  $P < 0.0001$ ), posterior wound location ( $P < 0.0001$ ), assault injury (OR, 2.22;  $P = 0.02$ ), orbital fracture (OR, 5.73;  $P < 0.0001$ ), lid laceration (OR, 2.78;  $P = 0.004$ ), hyphema (OR, 7.88;  $P < 0.0001$ ), retinal tear or detachment (OR, 8.37;  $P < 0.0001$ ), vitreous hemorrhage (OR, 32.9;  $P < 0.0001$ ), and lens damage (OR, 2.64;  $P = 0.04$ ) all were associated with worse final outcome (Table 2). However, an intraocular foreign body (OR, 0.40;  $P = 0.07$ ) was somewhat associated with a better outcome, and endophthalmitis was not associated with outcome, most likely because of the small number of endophthalmitis cases.

## Classification Tree (Classification and Regression Tree Model)

The classification tree was constructed using the 214 patients with open globe injury and nonmissing final visual acuity outcomes. Among open globe patients, the highest discriminatory variable for vision survival or no vision was presence or absence of an rAPD (Fig 1, classification tree), with the highest improvement in deviance of 50.1. Absence of an rAPD was the best predictor of vision survival, and no further splitting was necessary in this arm. Of 131 eyes without an rAPD, only 4 injuries (3.1%) resulted in complete loss of vision. The other 127 patients (96.9%) in this arm maintained some vision.

If an injured eye showed the presence of an rAPD, the next discriminatory variable was initial vision. Initial vision better than HM predicted vision survival, initial vision of NLP predicted no vision, and initial vision of LP was predicted further by the presence of lid laceration and wound location predictors. If there was a lid laceration associated with the open globe injury (in an eye with an rAPD and LP vision), most of these patients achieved a no vision outcome. If there was not a lid laceration, anterior wound location predicted a better outcome. In the cohort used to grow the tree, the sensitivity of the tree to identify correctly a no vision outcome was 80.4%, and the specificity to identify correctly vision survival was 93.0%.

To validate the CART model, 48 patients were followed up with the goal to compare their actual visual outcome with the outcome predicted by tree grown from the CART model. The validation data set consisted of 48 patients seen from January 1, 2005, through October 15, 2005, as well as the 3 fellow eyes that were not used to construct the tree. There were 38 (74.5%) men in this sample, and the median age was 31 years (IQR, 20–45 years; range, 6–94 years). Using the tree to predict no vision in the validation cohort, the tree had 85.7% sensitivity to correctly predict a no vision outcome and 91.9% specificity to predict correctly vision survival (Table 3).

Although the validation set seemed to have better sensitivity and specificity than the data used to build the tree, there was no difference in sensitivity ( $P = 1.0$ , Fisher exact test) or specificity ( $P = 1.0$ ) between the training sample outcomes and the validation sample outcomes.

## Minimal to Severe Vision Loss versus Profound Vision Loss

When a secondary split of the outcome was assessed, with the divide set between minimal to severe vision loss (with final vision of 20/400 or better) versus profound vision loss (with final vision worse than 20/400, including 20/500 to NLP, enucleation, or evisceration), only a slightly different prediction tree was constructed (Fig 2). The presence of an rAPD was still considered the most important predictor of vision survival. Of patients with an rAPD, 91.6% achieved a profound vision loss outcome (vision worse than 20/400). Initial visual acuity is the second node in this model, and 94.7% of patients with initial vision between 20/20 and 20/400 achieved a final visual outcome of 20/400 or better. However, in patients without an rAPD and with initial vision worse than 20/400, the presence of a rupture-type open globe injury and age older than 38.5 years predicted a worse outcome. In the separate validation sample, this secondary prognostic tree had 67% sensitivity to predict correctly minimal to severe vision loss and 89% specificity to predict correctly profound vision loss.

**Table 2.** Univariate Analysis of Patient Characteristics of Final Visual Outcome in Retrospective Cohort (n = 214)

	Visual Survival (n = 158), %	No Vision (n = 56), %	Odds Ratio*	P Value†
Age range (yrs)				
2–9	15 (9.5%)	3 (5.4%)		
10–29	52 (32.9%)	14 (25.0%)		
30–49	51 (32.3%)	22 (39.3%)	0.60	
50–69	20 (12.7%)	9 (16.1%)		
70+	20 (12.7%)	8 (14.3%)		
Gender				
Male	120 (76.0%)	40 (71.4%)		
Female	37 (23.4%)	16 (28.6%)	1.30	0.46
Missing	1 (0.6%)	0 (0%)		
Initial visual acuity				
≤20/40	17 (10.8%)	0 (0%)		
>20/40 to ≤20/400	36 (23.7%)	0 (0%)		
>20/400 to CF	15 (9.5%)	0 (0%)		
Hand movements	47 (29.8%)	2 (3.6%)	<0.0001	
Light perception	31 (19.6%)	21 (37.5%)		
NLP/enucleation/ evisceration	6 (3.8%)	33 (58.9%)		
Missing	6 (3.8%)	0 (0%)		
rAPD				
No	124 (78.5%)	4 (7.1%)		
Yes	30 (19.0%)	52 (93.0%)	53.7	<0.0001
Missing	4 (2.5%)	0 (0%)		
Mechanism				
Rupture	94 (59.5%)	8 (14.3%)		
Laceration	63 (40.0%)	48 (85.7%)	9.0	<0.0001
Missing	1 (0.6%)	0 (0%)		
Wound location				
Zone I	72 (45.6%)	12 (21.4%)		
Zone II	66 (41.8%)	23 (41.1%)		
Zone III	19 (12.0%)	21 (37.5%)	<0.0001	
Missing	1 (0.6%)	0 (0%)		
Cause of injury				
Accidental	128 (81.0%)	37 (66.1%)		
Intentional/assault	28 (17.7%)	18 (32.1%)	2.22	0.02
Missing	2 (1.3%)	1 (1.8%)		
Intraocular foreign body				
No	127 (80.4%)	51 (91.1%)		
Yes	31 (19.6%)	5 (8.9%)	0.40	0.07
Orbital fracture				
No	145 (91.8%)	37 (66.1%)		
Yes	13 (8.2%)	19 (33.9%)	5.73	<0.0001
Lid laceration				
No	135 (85.4%)	38 (67.9%)		
Yes	23 (14.6%)	18 (32.1%)	2.78	0.004
HypHEMA				
No	68 (43.0%)	5 (8.9%)		
Yes	88 (55.7%)	51 (91.1%)	7.88	<0.0001
Missing	2 (1.3%)	0 (0%)		
Endophthalmitis				
No	157 (99.4%)	55 (98.2%)		
Yes	1 (0.6%)	1 (1.8%)	2.85	0.44
Retinal detachment/tear				
No	124 (78.5%)	17 (30.4%)		
Yes	34 (21.5%)	39 (69.6%)	8.37	<0.0001
Vitreous hemorrhage				
No	89 (56.3%)	2 (3.6%)		
Yes	65 (41.1%)	48 (85.7%)	32.9	<0.0001
Missing	4 (2.5%)	6 (10.7%)		

(continued)

**Table 2. (Continued.)**

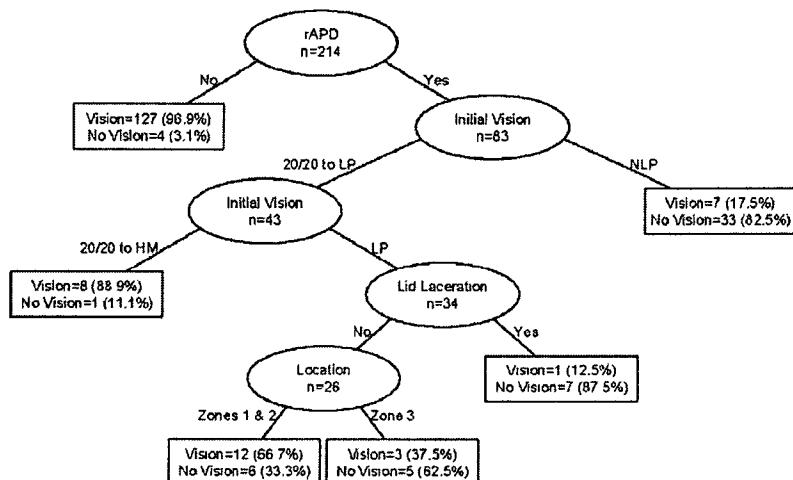
	Visual Survival (n = 158), %	No Vision (n = 56), %	Odds Ratio*	P Value†
Lens damage				
No	59 (37.3%)	6 (10.7%)		
Yes	93 (58.9%)	25 (44.6%)	2.64	0.04
Missing	6 (3.8%)	25 (44.6%)		
CF = counting fingers; NLP = no light perception; rAPD = relative afferent papillary defect.				
*For dichotomous variables; odds ratio calculated from nonmissing values.				
†P value calculated from nonmissing values.				

## 26% No Vision Outcome and 20% Secondary Enucleation Rates

In the cohort of open globe injuries treated from January 1, 2001, through December 31, 2004, 26% (n = 56) of patients achieved a no vision outcome (including NLP, enucleation, and evisceration outcomes). The rate of secondary enucleation or evisceration for this cohort was 20% (n = 43). This high rate of no vision outcome and secondary enucleation or evisceration is not because reconstruction was not attempted in eyes with severe trauma. In fact, quite the opposite is true. All open globe injuries treated from January 1, 2001, through December 31, 2004, underwent primary repair within 24 hours of arriving at the Wilmer Ophthalmological Institute. In this series, no open globe injury was treated with primary enucleation. Even in instances where most of the globe's contents, including the retina, were lost, all severely traumatized eyes underwent primary closure of the wound within 24 hours of arriving at the Wilmer Ophthalmological Institute. After repair, patients were admitted to and cared for in the Wilmer inpatient unit.

Fifty-one of 56 eventual NLP eyes underwent repair within 24 hours from injury. Five eventual NLP eyes were delayed in their presentation to Wilmer and underwent repair later than 24 hours from injury. Of these 5 patients, 2 patients underwent repair of their open globe injury within 48 hours of injury, 1 patient underwent repair within 72 hours of injury, 1 patient underwent repair 4 days after injury, and 1 patient underwent repair 7 days after injury. Again, no eye was enucleated primarily, and every effort was made to reconstruct the open globe. At the same time as the primary repair of open globe injury, 8 of 56 eventual NLP eyes underwent primary vitrectomy, 7 of 56 eventual NLP eyes underwent primary lensectomy, and 5 of 56 eventual NLP eyes had a primary scleral buckle placed. A secondary vitreoretinal reconstructive surgery was attempted in 5 of 56 eyes that eventually achieved a no vision outcome.

Loss of LP in the immediate postinjury period did not alter the treatment plan. In fact, 6 eyes with initial NLP vision underwent successful reconstruction and were able to maintain vision. Of those eyes with initial NLP vision, 1 eye achieved a final vision of counting fingers, 2 achieved HM vision, and 3 achieved LP vision. Of the 43 eyes that underwent secondary enucleation or evisceration, the median time before surgery was 90 days (IQR, 28.5–246.5 days; range, 5–990 days after primary repair). For the 43 eyes that underwent a second surgery for enucleation or evisceration, surgery was performed only when it was clear the eye was destroyed and could not be reconstructed anatomically or there was no hope for any vision (i.e., most of globe's contents had been lost).



**Figure 1.** Vision survival versus no vision outcome decision tree for patients with open globe injuries showing data on 214 patients for model building. Values in percentages represent the likelihood of a vision survival or no vision outcome. HM = hand movements; LP = light perception; NLP = no light perception; rAPD = relative afferent pupillary defect. Ovals, intermediate subgroups subject to further splitting; squares, terminal prognostic groups.

## Discussion

The authors created a decision tree for predicting vision outcome after open globe injury and validated the prognostic value of the tree in a separate cohort of patients. Although the final visual outcome after open globe injury often remains in doubt for weeks or even months after eye injury, most patients immediately request some sort of information regarding their projected visual outcome. For the patient, information about their likelihood of maintaining some vision may provide anxiety relief and may allow for more informed decision making. Engendering false hope or unnecessary anxiety is not effective communication with a patient. Instead, what is needed is objective data regarding an eye's functional prognosis. Until recently, such a prognostic system had not been described. The OTS recognized the need for reliable information regarding outcome after eye injury; however, the OTS has never been validated prospectively. Furthermore, it is not clear whether the OTS, which is designed to evaluate all types of severe ocular trauma, is the optimal model for predicting visual outcome in the unique subset of open globe trauma patients.

With this in mind, the authors developed the open globe outcome classification tree. What is novel about this model is that it is a highly sensitive and specific tool useful in predicting outcome after open globe injury. This classifica-

tion tree has clinical applications in counseling patients, making clinical decisions, and researching trauma therapies that may improve outcome. The high degree of accuracy of the open globe outcome classification tree stems from the distinctive characteristics of classification trees in processing predictor variables. A classification tree permits evaluation of the effects of the predictor variables one at a time rather than all at once. The implication of such examination enables classification trees to perform univariate splits that can be used to make decision nodes for categorical, continuous predictors or any mix of the 2 types. The CART technique has been used previously in medical applications as a classification tool. In particular, it has been used successfully in diagnosis decision processes<sup>45,46</sup> and prognosis ascertainment.<sup>47</sup> Other fields in where CART analyses have been performed recently include epidemiology,<sup>48</sup> genetics,<sup>49</sup> and pharmacology.<sup>50</sup>

### The Open Globe Outcome Prognostic Trees

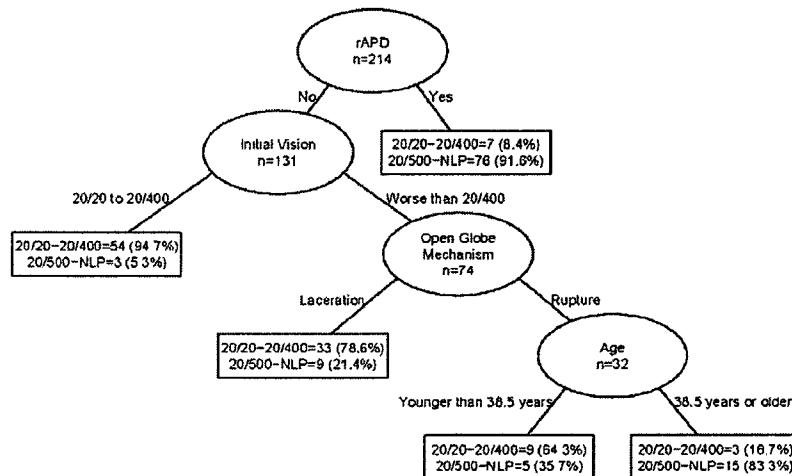
In this study, the authors differentiate between patients who maintain vision after an open globe injury from those patients who achieve a no vision outcome after an open globe injury. This model is limited in that it makes a distinction between only 2 broad outcome categories: vision survival versus no vision outcome. However, because this article addresses visual outcomes at last follow-up rather than visual acuity at specific follow-up times, the authors believe the vision survival versus no vision outcome analysis is the most reliable. Jabs<sup>51</sup> described how visual acuity outcomes are influenced by duration of follow-up.

The authors, however, also performed a secondary analysis to assess their ability to make a distinction between an eye that will have mild to severe vision loss (20/20 to 20/400 final vision) from an eye that will have profound vision loss (20/500 to NLP) after open globe injury. The prognostic tree produced in this second analysis was very similar to the tree produced in the primary analysis. However, with different end points for this second tree (minimal

**Table 3.** The Classification and Regression Tree Analysis Prediction Compared with Actual Outcome in Validation Dataset (n = 51)

	Actual Outcome	
	Vision Survival	No Vision
CART analysis predicts vision survival	34	2
CART analysis predicts no vision	3	12

CART = classification and regression tree.



**Figure 2.** Minimal to severe vision loss versus profound vision loss decision tree for patients with open globe injuries showing data on 214 patients for model building. Values in percentages represent the likelihood of minimal to severe vision loss (20/20–20/400) versus profound vision loss (20/500–no light perception [NLP], enucleation, and evisceration) outcomes. rAPD = relative afferent pupillary defect. Ovals, intermediate subgroups subject to further splitting; squares, terminal prognostic groups.

to severe vision loss versus profound vision loss outcome), all possible splits of the 14 predictors were considered again, and 4 variables (rAPD, initial vision, open globe mechanism, and age) best separated the data into the new outcome categories. The presence of an rAPD again was the most important predictor of outcome, and initial visual acuity was the second node in this model. However, lid laceration and location (zone) of injury were replaced by mechanism of injury and patient age in the second model. When the second independent sample of patient eyes seen from January 1, 2005, through October 15, 2005, was used to assess this prognostic tree, the tree had 67% sensitivity to predict correctly minimal to severe vision loss and 89% specificity to predict correctly profound vision loss. Therefore, although the vision survival versus no vision tree has a higher sensitivity and specificity prediction rate in the separate validation sample, this second tree, which assesses minimal to severe vision loss versus profound vision loss outcome, does provide useful clinical information.

### Vision Survival versus No Vision Outcome Tree

The results of this model reinforce many previous findings of predictors of outcome for open globe injury. The presence of an rAPD, presence of poor initial vision, presence of adnexal injury such as a lid laceration, and presence of more posterior injuries all predict poor outcome. Although 14 potential prognostic predictors were considered in this study, 4 variables best separated the data into the 2 outcome groups (vision survival versus no vision outcome). Therefore, rAPD, initial vision, presence of adnexal injury, and zone of injury were selected as the predictors of visual outcome for the classification tree. Remember, however, that all variables have been shown to be effective predictors in the univariate analysis. And, the fact that a predictor does not appear in the tree does not necessarily reflect a lack of relationship. This relationship may be subsumed by another variable.<sup>52</sup>

### Presence of a Relative Afferent Papillary Defect

The CART analysis shows that, of the clinical signs at presentation, the presence of an rAPD is the most significant in predicting outcome after open globe injury. If an rAPD is present, the outcome is significantly worse than if not present. In all, 62.7% ( $n = 52$ ) of open globe injuries proceeded to an eventual no vision outcome if an rAPD was present at initial examination compared with 3.1% ( $n = 4$ ) with a no vision outcome if an rAPD was not present at initial examination. Pieramici et al<sup>26</sup> also showed, in a series of 288 patients, that 55% of eyes were enucleated if an rAPD was documented at presentation, compared with 7% in the absence of an rAPD.

### Initial Vision

Initial vision is a key predictor in the open globe outcome prognostic tree and was found to correlate significantly with outcome. Poor initial visual acuity has been shown by other authors to be a predictor for enucleation and, thus, poor visual outcome. Pieramici et al<sup>26</sup> described a significantly reduced rate of enucleation if the presenting visual acuity was 20/200 or better, whereas 34% of those with a presenting visual acuity of worse than 20/200 underwent eventual enucleation. Groessl et al<sup>24</sup> found that an initial visual acuity of HM or better correlated with a good outcome. The result of this study confirm that a visual acuity worse than HM has a significantly inferior outcome compared with an initial visual acuity of HM or better.

### Lid Laceration

Lid laceration, a marker for adnexal injury, is the third node in the prognostic model. In this series, the authors found a higher rate of no vision and worse visual outcome in those patients with injuries associated with lid lacerations and adnexal injury, often as a result of blunt injuries. This is not

surprising, because blunt injuries resulting from assaults and falls are associated with complex corneoscleral ruptures with posterior wound locations. Support for this result can be found in the work of Hatton et al,<sup>53</sup> who evaluated adnexal injury and showed in a series of 300 patients with open globe injury that orbital and adnexal injury was associated with worse initial vision. Additionally, Rahman et al,<sup>36</sup> in a series of 107 open globe injuries repaired at the Manchester Royal Eye Hospital, Manchester, United Kingdom, reported that the presence of a lid laceration in binary logistic regression analysis was associated with eventual enucleation (OR, 5.58;  $P = 0.01$ ).

### Zone of Injury

Wound location in the CART model is defined according to the Ocular Trauma Classification Group<sup>42</sup> and is the final node in the prognostic tree. Zone I open globe injuries are confined to the cornea and limbus, zone II injuries involve the anterior 5 mm of the sclera (not extending into the retina), and zone III injuries involve full-thickness scleral defects more posterior than 5 mm from the limbus. Johnston<sup>38</sup> reviewed 376 cases of open globe injury and correlated posterior wound locations (wound categories: corneal, limbal, corneoscleral, and scleral) with poorer visual prognosis. In this prognostic tree, zone of injury predicts visual outcome in patients with the presence of an rAPD, initial LP vision, and no evidence of a lid laceration. The more posterior the wound extends, the greater the probability of a no vision outcome. Clinically this makes sense, because when the retina or optic nerve becomes involved, irreparable damage can occur, so that, despite anatomic correction, visual acuity may remain limited.

### High No Vision Outcome and Enucleation Rates

In the cohort of open globe injuries treated from January 1, 2001, to December 31, 2004, 26% ( $n = 56$ ) of patients achieved a no vision outcome, and the rate of secondary enucleation or evisceration for this cohort was 20% ( $n = 43$ ). This rate is less than the rates reported in the literature by Pieramici et al,<sup>26</sup> who in 1996 reported a 24% enucleation rate for open globe injuries treated between 1985 and 1993 and a 30% enucleation rate for open globe injuries treated between 1970 and 1981 at the Wilmer Ophthalmological Institute. The 27% NLP final vision and 20% total enucleation rate reported by Casson et al<sup>54</sup> in a series of 109 open globe injuries closely correlates with the rates in this series. However, the enucleation rate in this series is higher than the 12% secondary enucleation rate reported by Rahman et al,<sup>36</sup> the 11% enucleation rate reported by Dunn et al,<sup>55</sup> and the 15% total enucleation rate reported by Rofail et al.<sup>56</sup>

This high rate of no vision outcome and secondary enucleation or evisceration is not because reconstruction was not attempted in eyes with severe trauma. In fact, quite the opposite is true. As a designated eye trauma center of the Maryland Institute for Emergency Medical Services Systems, the Wilmer Ophthalmological Institute delivers 24-hour-a-day care for open globe injuries and other eye injuries, with fast-track assessment and treatment. In this series,

no open globe injury was treated with primary enucleation. Even in instances where most of the globe's contents, including the retina, were lost, all severely traumatized eyes underwent primary closure of the wound within 24 hours of arriving at the Wilmer Ophthalmological Institute. The authors believe that their 26% no vision rate, despite proper reconstruction efforts, is a result of a referral bias. The severity of injury referred to the Wilmer Ophthalmological Institute is the most complex of open globe cases. In the cohort of open globe injuries treated from January 1, 2001, through December 31, 2004, patients were referred to Wilmer from 9 different states (Maryland, Virginia, Pennsylvania, West Virginia, Delaware, Connecticut, Louisiana, Mississippi, and Minnesota), the District of Columbia, and 2 foreign countries (Kuwait and the United Arab Emirates).

### Summary

A classification tree is a useful way to look at the visual prognosis of open globe injuries. Among the advantages of the classification trees presented in this study are that the indices chosen in the development of the trees are readily available in the routine ophthalmic examination at the patient's initial visit. This allows stratification of patient's risk of losing all vision and provides healthcare workers with valuable information for patients and their families in making informed treatment decisions. The tree diagram, illustrating the prognostic pattern, provides threshold values that split open globe injuries into subgroups with varying degrees of risk of a no vision outcome. The two trees constructed in this study were validated, with rAPD and initial vision being highly predictive of vision survival.

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threshold for work RVUs of 0.5 RVUs or less, would produce a reasonable number of services for the RUC to review that have substantial total work RVUs for the comprehensive service furnished during a single treatment. That is, as a general example, with a work RVU threshold of 0.5 RVUs and a multiple threshold of 5 per day, the total work RVUs for a typical treatment would equate to 2.5 RVUs, which is approximately comparable to a high level office visit, an interpretation of a complex imaging procedure, or a minor surgical procedure.

We are asking the AMA RUC to review the codes in Table 10.

**TABLE 10—CODES WITH LOW WORK RVUS THAT ARE COMMONLY BILLED IN MULTIPLE UNITS REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
95904 .....	Sense nerve conduction test.
17003 .....	Destruct premalg les, 2–14.
95004 .....	Percut allergy skin tests.
11101 .....	Biopsy, skin add-on.
95024 .....	Id allergy test, drug/bug.
76000 .....	Fluoroscope examination.
95144 .....	Antigen therapy services.
95010 .....	Percut allergy titrate test.
88300 .....	Surgical path, gross.
95027 .....	Id allergy titrate-airborne.
95015 .....	Id allergy titrate-drug/bug.
95148 .....	Antigen therapy services.

#### c. Codes With High Volume and Low Work RVUs

We believe that codes that have low work RVUs but are high volume based on claims data are another category of potentially misvalued codes. Although these codes have low work RVUs (less than or equal to 0.25 RVUs), the high utilization of these codes represents significant expenditures under the PFS such that their appropriate valuation is especially important. Table 11 contains a list of such codes and we are requesting that the AMA RUC review these codes.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW**

CPT Code	Short descriptor
71010 .....	Chest x-ray.
73510 .....	X-ray exam of hip.
97035 .....	Ultrasound therapy.
88313 .....	Special stains group 2.
73630 .....	X-ray exam of foot.
72100 .....	X-ray exam of lower spine.
73030 .....	X-ray exam of shoulder.
73562 .....	X-ray exam of knee, 3.
73560 .....	X-ray exam of knee, 1 or 2.
94010 .....	Breathing capacity test.

**TABLE 11—CODES WITH LOW WORK RVUS THAT ARE HIGH VOLUME REFERRED FOR AMA RUC REVIEW—Continued**

CPT Code	Short descriptor
77052 .....	Comp screen mammogram add-on.
88304 .....	Tissue exam by pathologist.
73564 .....	X-ray exam, knee, 4 or more.
72170 .....	X-ray exam of pelvis.
74000 .....	X-ray exam of abdomen.
73610 .....	X-ray exam of ankle.
111719 .....	Trim nail(s).
73620 .....	X-ray exam of foot.
92567 .....	Tympanometry.
73110 .....	X-ray exam of wrist.
73130 .....	X-ray exam of hand.
93701 .....	Bioimpedance, cv analysis.
72040 .....	X-ray exam of neck, spine.
92543 .....	Caloric vestibular test

#### d. Codes With Site-of-Service Anomalies

In previous years, we requested that the AMA RUC review codes that, according to the Medicare claims database, have experienced a change in the typical site of service since the original valuation of the code. For example, we have found services that originally were provided in the inpatient setting but for which current claims data show the typical case has shifted to being furnished outside the inpatient setting. Since the procedures were typically performed in the inpatient setting when the codes were originally valued, the work RVUs for these codes would have been valued to include the inpatient physician work provided, as well as to reflect the intensive care and follow-up normally associated with an inpatient procedure. If the typical case for the procedure has shifted from the inpatient setting to an outpatient or physician's office setting, it is reasonable to expect that there have been changes in medical practice, and that such changes would represent a decrease in physician time or intensity or both. The AMA RUC reviewed and recommended to CMS revised work RVUs for 29 codes for CY 2009 and 11 codes for CY 2010 that were identified as having site-of-service anomalies.

In the CY 2010 PFS proposed and final rules with comment period (74 FR 33556 and 74 FR 61777, respectively), we encouraged the AMA RUC to utilize the building block methodology when revaluing services with site-of-service anomalies. Specifically, where the AMA RUC has determined in its review that changes in the inclusion of inpatient hospital days, office visits, and hospital discharge day management services (that is, the “building blocks” of the

code) are warranted in the revaluation of the code, we asked the AMA RUC to adjust the site-of-service anomaly code for the work RVUs associated with those changes.

Additionally, we suggested that in cases where the AMA RUC has adjusted the pre-service, intra-service and post-service times of the code under review, the AMA RUC should also make associated work RVU adjustments to account for those changes. However, we remain concerned that in the AMA RUC's recommendations of the work RVUs for the CYs 2009 and 2010 site-of-service anomaly codes, the AMA RUC may have determined that eliminating or reallocating pre-service and post-service times, hospital days, office visits, and hospital discharge day management services was appropriate to reflect the typical case that is now occurring in a different setting, but the work RVUs associated with those changes may not have been systematically extracted or reallocated from the total work RVU value for the service.

In the CYs 2009 and 2010 PFS final rules with comment period (73 FR 69883 and 74 FR 61776 through 61778, respectively), we indicated that although we would accept the AMA RUC valuations for these site-of-service anomaly codes on an interim basis through CY 2010, we had ongoing concerns about the methodology used by the AMA RUC to review these services. We requested that the RUC reexamine the site-of-service anomaly codes and use the building block methodology to revalue the services (74 FR 61777). We also stated that we would continue to examine these codes and consider whether it would be appropriate to propose additional changes in future rulemaking.

Accordingly, in preparation for CY 2011 rulemaking, we conducted a comprehensive analysis of the codes that the AMA RUC reviewed for CYs 2009 and 2010 due to site-of-service anomaly concerns. We systematically applied the reverse building block methodology to the 29 codes from CY 2009 and 11 codes from CY 2010 as follows:

- First, we obtained the original work RVU value assigned to the code (this is the “starting value”) and made a list of the building block services with RVUs that were originally associated with the code (that is, before the AMA RUC reviewed the code for site-of-service anomalies).

- Next, we examined the AMA RUC recommended changes to the building blocks of the code.

- We then deducted the RVUs associated with the AMA RUC's recommended eliminations from the code's starting RVU value.

Generally, the AMA RUC eliminated inpatient hospital visit building blocks from the value of the code since the site-of-service for the code has shifted from the inpatient setting to another setting. We note in some cases, the AMA RUC left an inpatient hospital visit in the valuation of the code. We believe this is inconsistent with the change in the site of service to non-inpatient settings. Accordingly, we adhered to the methodology and deducted the RVUs associated with all inpatient hospital visits from the starting value. In cases where the AMA RUC recommended adding or substituting outpatient visits, we also added or substituted the RVUs associated with those changes to the starting value. If the AMA RUC recommended changes to the pre-, intra-, or post-service times, we calculated the incremental change in RVUs associated with that time and either added or deducted that RVU amount from the starting value. We note

that the RVU values associated with the incremental time change are calculated using the intensity associated with the particular pre-, intra-, or post period. For the intensity of the intra-service period, we utilized the original IPUT associated with the code. The AMA RUC generally recommended allowing only half of a hospital discharge day management service for the site-of-service anomaly codes. That is, CPT code 99238 (Hospital discharge day management; 30 minutes or less) has a work RVU value of 1.28; therefore, half the value associated with CPT code 99238 is 0.64. Accordingly, if a code had one CPT code 99238 listed as part of the original valuation, we deducted 0.64 RVUs from the starting value.

We standardized the methodology so that each of the site-of-service anomaly codes has half of a hospital discharge day management service value accounted in the valuation. Finally, we note that while we eliminated the RVUs associated with all inpatient hospital visits built into the code's starting value, because the typical case no longer occurs in the inpatient setting, we

allowed for the possibility that in some cases, some part of the work which had been performed in the inpatient setting may continue to be provided even in the outpatient setting. Therefore, to be conservative in our deductions of work RVUs associated with the inpatient hospital codes from the starting values, we allowed the intra-time of any inpatient hospital visits included in the original valuation to migrate to the post-service period of the code. Accordingly, while we deducted the full RVUs of an inpatient hospital visit from the starting value, we added the intra-service time of the inpatient hospital visit to the post-service time of the code and accounted for the incremental change in RVUs. The following description provides an example of our methodology.

CPT code 21025 (Excision of bone (e.g., for osteomyelitis or bone abscess); mandible) has a starting value of 11.07 RVUs. Table 12 shows the building blocks that are included in the original valuation of the code.

TABLE 12

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Original IPUT
75 min .....	120 min . ..	43 min .....	1 visit (0.76 RVUs).	1 visit (1.39 RVUs)	1 visit (1.28 RVUs).	2 visits (0.36 RVUs).	2 visits (0.96 RVUs).	2 visits (1.94 RVUs).	0.0145

The AMA RUC removed two inpatient hospital visits and reduced the outpatient visits from 6 to 4 visits. Table

13 shows the building blocks that were recommended for CY 2009 by the AMA

RUC after its review of the code for site-of-service anomalies.

TABLE 13

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213	Revised IPUT
85 min ....	90 min . .....	30 min .....	.....	.....	.....	.....	2 visits .....	2 visits .....	0.0530

Next we calculated the RVUs associated with the changes to the building blocks recommended by the AMA RUC. We note that the immediate post-service value of 0.38 RVUs (Table 14) includes 30 minutes of intra-service time from inpatient hospital CPT code

99231 (Level 1 subsequent hospital care, per day). Also, the median intra-service value of 0.44 RVUs (Table 14) was determined using the starting IPUT value of 0.0145. Additionally, our methodology accounted for a half of a hospital discharge day management

service (CPT code 99238) for the site-of-service anomaly code. Table 14 shows the RVU changes to the building blocks that were calculated based on the methodology discussed above.

TABLE 14

Pre-service time	Median intra-service time	Immediate post-service time	99231	99232	99238	99211	99212	99213
0.22 RVUs ....	-0.44 RVUs	0.38 RVUs ...	-0.76 RVUs	-1.39 RVUs	-0.64 RVUs	-0.36 RVUs.		

In the final step, the RVUs associated with the changes to the building blocks

recommended by the AMA RUC (Table 14) were deducted from or added to the

starting value of 11.07 RVUs, which resulted in the CY 2011 reverse building

block value of 8.08 RVUs  
 $(11.07 + 0.22 - 0.44 + 0.38 - 0.76 - 1.39)$

$$- 0.64 - 0.36 = 8.08$$

The methodology discussed above was applied to each of the site-of-service

anomaly codes from CYs 2009 and 2010 and the results are summarized in Tables 15 and 16.

TABLE 15—CY 2009 SITE-OF-SERVICE ANOMALY CODES<sup>1</sup>

CPT code	Short descriptor	CY 2008 RVUs ("starting value")	RUC Recommended value for CY 2009	CY 2011 Reverse building block value
21025 .....	Excision of bone, lower jaw .....	11.07	9.87	8.09
23415 .....	Release of shoulder ligament .....	10.09	9.07	10.63
25116 .....	Remove wrist/forearm lesion .....	7.38	7.38	7.21
42440 .....	Excise submaxillary gland .....	7.05	7.05	6.52
52341 .....	Cysto w/ureter stricture tx .....	6.11	5.35	5.62
52342 .....	Cysto w/up stricture tx .....	6.61	5.85	6.20
52343 .....	Cysto/w/renal stricture tx .....	7.31	6.55	5.90
52344 .....	Cysto/uretero, stricture tx .....	7.81	7.05	5.58
52345 .....	Cysto/uretero w/up stricture .....	8.31	7.55	5.76
52346 .....	Cystouretero w/renal strict .....	9.34	8.58	6.05
52400 .....	Cystouretero w/congen repr .....	10.06	8.66	7.00
52500 .....	Revision of bladder neck .....	9.39	7.99	8.72
52640 .....	Relieve bladder contracture .....	6.89	4.73	5.01
53445 .....	Insert uro/ves nck sphincter .....	15.21	15.21	11.72
54410 .....	Remove/replace penis prosth .....	16.48	15.00	14.00
54530 .....	Removal of testis .....	9.31	8.35	8.88
57287 .....	Revise/remove sling repair .....	11.49	10.97	10.20
62263 .....	Epidural lysis mult sessions .....	6.41	6.41	6.99
62350 .....	Implant spinal canal cath .....	8.04	6.00	0.41
62355 .....	Remove spinal canal catheter .....	6.60	4.35	-0.43
62360 .....	Insert spine infusion device .....	3.68	4.28	-3.14
62361 .....	Implant spine infusion pump .....	6.59	5.60	-0.92
62362 .....	Implant spine infusion pump .....	8.58	6.05	-0.51
62365 .....	Remove spine infusion device .....	6.57	4.60	-0.35
63650 .....	Implant neuroelectrodes .....	7.57	7.15	4.25
63685 .....	Insr/redo spine n generator .....	7.87	6.00	4.80
64708 .....	Revise arm/leg nerve .....	6.22	6.22	6.17
64831 .....	Repair of digit nerve .....	10.23	9.00	8.87
65285 .....	Repair of eye wound .....	14.43	14.43	13.52

<sup>1</sup>We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

TABLE 16—CY 2010 SITE-OF-SERVICE ANOMALY CODES<sup>2</sup>

CPT code	Short descriptor	CY 2009 RVUs ("starting value")	RUC Recommended value for CY 2010	CY 2011 Reverse building block value
28120 .....	Part removal of ankle/heel .....	5.64	8.08	6.03
28122 .....	Partial removal of foot bone .....	7.56	7.56	6.79
28725 .....	Fusion of foot bones .....	11.97	11.97	12.41
28730 .....	Fusion of foot bones .....	12.21	12.21	10.06
36825 .....	Artery-vein autograft .....	10.00	15	13.12
42415 .....	Excise parotid gland/lesion .....	17.99	17.99	15.17
42420 .....	Excise parotid gland/lesion .....	20.87	20.87	17.80
49507 .....	Prp i/hern init block >5 yr .....	9.97	9.97	9.37
49521 .....	Rerepairing hernia, blocked .....	12.36	12.36	11.59
49587 .....	Rpr umbil hern, block > 5 yr .....	7.96	7.96	7.19
61885 .....	Insr/redo neurostim 1 array .....	7.37	7.57	3.22

<sup>2</sup>We note that in this table, we have not adjusted the RVUs for these codes for the RVU changes to the evaluation and management codes that resulted from the CY 2010 elimination of the consultation codes (74 FR 61775). However, we note that we may, if appropriate, adjust the RVUs for services with global periods to account for relevant changes in the RVUs for evaluation and management services as necessary.

For most codes in Tables 15 and 16, the CY 2011 reverse building block methodology produced a value that is somewhat lower than the AMA RUC-recommended value. While our results suggest that the majority of the codes

with site-of-service anomalies continue to be overvalued under the AMA RUC's most recent recommendations, we also found that the methodology may produce a result that is considerably reduced or, in several cases, a negative

value. We understand that in previous years, stakeholders have expressed confusion as to why the application of a building block methodology would produce negative values. We believe in some cases, the starting value, that is,

the original work RVU, may have been misvalued using building block inputs that were not consistent with the service, although the overall work value of the code may have been consistent with the values for other similar services. Moreover, a number of these services are the Harvard-valued codes, for which the RVUs were established many years ago based on historical inputs that may no longer be appropriate for the code. An attempt to extract the RVUs associated with these inappropriate inputs through the reverse building block methodology could produce aberrant results. Furthermore, in some cases, we noticed that the original IPUT of the code was negative even before the code was reviewed by the AMA RUC for a site-of-service anomaly. A negative value for the IPUT is counterintuitive to the IPUT concept, indicating that the code was originally misvalued at the building block level. At a minimum, we believe that in cases where the reverse building block methodology produces aberrant results, and where clinical review indicates a need for further analysis, the codes should be referred back to the AMA RUC for review and new valuation should be performed based on the building block methodology.

We note the application of the reverse building block methodology is an objective way to account for changes in the resources resulting from the change in the site-of-service in which the typical service is provided. However, because relative values under the PFS are "relative," that is, where work relative value units for a code are established relative to work relative value units for other codes, the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion. For example, we recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. This method of valuing services preserves relativity within the relative value scale for that code family. However, we have stated that we believe the relative value scale requires each service to be valued based on the resources used in furnishing the service as specified in section 1848(c)(1)(A) of the Act, which defines the physician work component to include "the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service." Furthermore, section 1848(c)(2)(C)(i) of the Act specifies that "the Secretary shall

determine a number of work relative value units (RVUs) for the service based on the relative resources incorporating physician time and intensity required in furnishing the service." Read together, these two sections of the statute support our intention to rely on the building block methodology to determine appropriate work RVUs for codes.

We note that we continue to rely on the extensive expertise provided by the AMA RUC to recommend appropriate input building blocks for codes. Additionally, the AMA RUC's unique infrastructure and broad perspective permits the valuation of a code within the context of relativity to the entire relative value system. Therefore, we believe that the recommended methodology of valuing services based on input building blocks is best applied within the context of the AMA RUC discussion.

Accordingly, we are requesting that the AMA RUC review the CPT codes displayed in Tables 15 and 16. In addition, where the application of the CY 2011 reverse building block methodology produces an aberrant result that is clearly not a reflection of physician work for the service, we are requesting that the AMA RUC review the input building blocks and recommend an appropriate RVU value that is both consistent with the building blocks of the code and appropriate relative to the values for other codes in the family. For other codes where the application of the CY 2011 reverse building block methodology produces a result that is consistent with the physician work for the service, we encourage the AMA RUC to confirm the values and recommend these work values for CY 2011. In this way, we would hope to receive new AMA RUC recommendations for all of the codes in Tables 15 and 16 for CY 2011. Furthermore, if the recommendations that we receive from the AMA RUC are not consistent with the building block methodology and not appropriate relative to the values of other services, and the application of the CY 2011 reverse building block methodology produces a result that CMS medical advisors believe is consistent with the work for the service, we are proposing to adopt the CY 2011 reverse building block methodology values that are listed in Tables 15 and 16 for CY 2011. In cases where the reverse building block methodology produces a negative work value, we are suggesting that the AMA RUC review and revise the building blocks of the code so that a new valuation can be determined based on the building block methodology. For such codes, if the revised

recommendations that we would hope to receive from the AMA RUC are still not consistent with the building block methodology upon revision, because we cannot pay for these services based on negative work RVUs, we are proposing to modify the AMA RUC-recommended values for these codes as CMS determines clinically appropriate and adopt the CMS-modified RVUs on a interim final basis for CY 2011.

In their future work, we urge the AMA RUC to use the building block methodology when valuing services or provide CMS with extensive rationale for cases where the AMA RUC believes the building block methodology is inappropriate for a specific code. Since section 1848(c)(2)(L) (as added by section 3134 of the ACA) specifies that the Secretary shall establish a process to validate work RVUs of potentially misvalued codes under the PFS, as we have discussed earlier in this section, we believe codes that are valued using the building block methodology would be more likely to meet the standards of a systematic RVU validation process that could be developed in accordance with the requirements of the statute.

#### e. Codes With "23-hour" Stays

In the CY 2010 PFS proposed rule (74 FR 33557), we requested that the AMA RUC review services that are typically performed in the outpatient setting and require a hospital stay of less than 24 hours. We stated in the proposed rule that we believed these to be primarily outpatient services and expressed concern that the value of evaluation and management (E/M) visits for inpatients was inappropriately included in the valuation of codes that qualify as "23-hour stay" outpatient services.

We received a number of comments in response to the discussion in the CY 2010 proposed rule. The AMA RUC stated that it already values stays of less than 23 hours appropriately by reducing the hospital discharge day management service (that is, CPT code 99238), from 1 day to a half day. The AMA RUC also explained that when the AMA RUC refers to 23-hour stay services in discussions at AMA RUC meetings, it is referring primarily to services that are reported in the Medicare claims database as typically outpatient services, but where the patient is kept overnight and, on occasion, even longer in the hospital. Because the AMA RUC believes the patient stays overnight in the hospital, it believes the inclusion of inpatient E/M visits to be appropriate in the valuation of this category of codes.

We believe that the 23-hour stay issue encompasses several scenarios. The typical patient is commonly in the

Tables 15 & 16 June 2010 Proposed Rule - CMS Request for RUC Re-Review																					
CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99261	99262	99263	99264	99265	99266	99267	Total Time	IWPUT	Specialty Societies	Review
21025	EXCISION OF BONE, LOWER JAW	11.07	2008	75				75	120	43	2	2	2	1	1	1	428	0.0145		Pre-RUC Evaluation	
		10.03	2010	1,123	60	10	15	85	90	30	2	2	2				283	0.0530	AAOMS	Post-RUC Evaluation	
23415	RELEASE OF SHOULDER LIGAMENT	10.09	2008	49				49	62	23	3.5		0.5	1	1	1	238	0.0886		Pre-RUC Evaluation	
		9.23	2010	1,237	40	15	15	70	60	20	2.0	2.0		0.5	0.5	1	247	0.0648	AAOS	Post-RUC Evaluation	
25116	REMOVE WRIST/FOREARM LESION	7.38	2009	36				36	78	21	5.0		1.5	1.0	1.0	1.0	283	0.0192		Pre-RUC Evaluation	
		7.56	2010	1,030	40	10	15	65	60	20	1.0	3.0		0.5	0.5	1.0	249	0.0307	ASSH, AAOS, ASPS	Post-RUC Evaluation	
27792	TREATMENT OF ANKLE FRACTURE	7.91	2007	21				83	19	4.0			1.5		1.0		281	0.0513	AAOS, AOFAS	Pre-RUC Evaluation	
		9.71	2010	6,020	40	10	15	65	60	20	2.0	2.0		1.0	1.0	1.0	259	0.0056	AOFAS	Post-RUC Evaluation	
28120	PART REMOVAL OF ANKLE/HEEL	5.64	2009	47				47	67	21	3.5		1.5		1.0	1.0	280	0.0263	AAOS, APMA	Post-RUC Evaluation	
		8.27	2010	3,851	33	10	15	58	50	20	3.0	2.0		1.0	1.0	1.0	268	0.0304	APMA	Pre-RUC Evaluation	
28122	PARTIAL REMOVAL OF FOOT BONE	7.56	2009	43				43	51	26	5.0		1.5		1.0	1.0	264	0.0249	AAOS, APMA	Post-RUC Evaluation	
		7.72	2010	10,359	33	10	15	58	50	20	2.0	2.0		1.0	1.0	1.0	313	0.0631		Pre-RUC Evaluation	
28725	FUSION OF FOOT-BONES	11.97	2009	50				50	89	22	4.0		2.5		1.0	1.0	339	0.0496	AAOS, APMA	Post-RUC Evaluation	
		12.18	2010	2,817	45	10	15	70	90	20	2.0	3.0	1.0		1.0	1.0	349	0.0331	AAOS	Pre-RUC Evaluation	
28730	FUSION OF FOOT-BONES	12.21	2009	60				60	120				5.0		1.0		383	0.0331		Pre-RUC Evaluation	
		12.42	2010	1,656	45	10	15	70	100	20	2.0	3.0	1.0		1.0	1.0	349	0.0471	AAOS	Post-RUC Evaluation	
28825	PARTIAL AMPUTATION OF TOE	3.71	2008	17				25	42	36	16	3.5		0.5		1.0	198	0.0151	ACS, SVS, APMA	Pre-RUC Evaluation	
		6.01	2010	9,014	33	10	15	58	30	20	2.0	2.0		1.0	1.0	1.0	224	0.0099	AAOS	Post-RUC Evaluation	
36821	AV FUSION DIRECT ANY SITE	9.15	2008	29				25	54	28	2.5		1.5		1.0	1.0	265	0.0540		Pre-RUC Evaluation	
		12.11	2010	34,130	33	10	10	53	90	20	2.0	1.0		1.0	1.0	1.0	256	0.0823	ACS, SVS, RPA	Post-RUC Evaluation	
36825	ARTERY-VEIN AUTOGRAPH	10.00	2009	56				56	81	22	2.5		1.0		1.0	1.0	257	0.0663		Pre-RUC Evaluation	
		15.13	2010	4,873	40	10	20	70	120	30	1.0	2.0		1.0	1.0	1.0	340	0.0726	ACS, SVS	Post-RUC Evaluation	
42415	EXCISE PARTOID GLAD/LESION	17.99	2009	55				55	156	37	3.5		1.5		1.0	1.0	396.5	0.0671		Pre-RUC Evaluation	
		18.12	2010	4,464	40	12	20	72	150	20	1.0	2.0		1.0	1.0	1.0	342	0.0843	ACS, AAO-HNS	Post-RUC Evaluation	
42420	EXCISE PARTOID GLAD/LESION	20.87	2009	57				57	182	22	3.5		3.0	1.0	1.0	1.0	439.5	0.0687		Pre-RUC Evaluation	
		21.00	2010	1,624	40	12	20	72	180	20	1.0	2.0		1.0	1.0	1.0	432	0.0743	ACS, AAO-HNS	Post-RUC Evaluation	
42440	EXCISE SUBMAXILLARY GLAND	7.05	2009	47				47	71	19	1.5		0.5		1.0	1.0	209	0.0500		Pre-RUC Evaluation	
		7.13	2010	2,088	30	10	15	55	60	20	1.0	1.0		0.5	0.5	1.0	193	0.0596	AAO-HNS, ACS	Post-RUC Evaluation	
49507	PRP I/HERN INIT BLOCK >5 YR	9.97	2009	45				45	67.5	30			1.0	1.0		1.0	239.5	0.0711		Pre-RUC Evaluation	
		10.05	2010	11,879	40	3	20	63	70	30	1.0	1.0		1.0	1.0	1.0	260	0.0680	ACS	Post-RUC Evaluation	
49521	REREPAIR ING HERNIA, BLOCKED	12.36	2009	45				45	90	30	1.0	1.0		1.0	1.0	1.0	262	0.0799		Pre-RUC Evaluation	
		12.44	2010	2,815	40	3	20	63	90	30	1.0	1.0		1.0	1.0	1.0	260	0.0795	ACS	Post-RUC Evaluation	
49587	RPR UNBL HERN, BLOCK >5 YR	7.96	2009	45				45	60	30	1.0	1.0		1.0	1.0	1.0	232	0.0465		Pre-RUC Evaluation	
		8.04	2010	9,212	40	3	20	63	60	30	1.0	1.0		1.0	1.0	1.0	250	0.0459	ACS	Post-RUC Evaluation	
49652	LAP VENT/ABD HERNIA REPAIR	12.88	2010	45	15	15	75	90	30	1.0	1.0		1.0	1.0	1.0	292	0.0806	ACS	New Code in 2009		
49653	LAP VENT/ABD HERN PROC COMP	16.21	2010	45	15	15	75	120	30	2.0	1.0		1.0	1.0	1.0	378	0.0726	ACS	New Code in 2009		
49654	LAP INC HERNIA REPAIR	15.03	2010	45	15	15	75	120	30	1.0	1.0		1.0	1.0	1.0	362	0.0668	ACS	New Code in 2009		
49655	LAP INC HERN REPAIR COMP	18.11	2010	50	15	15	80	150	30	2.0	1.0		1.0	1.0	1.0	413	0.0700	ACS	New Code in 2009		
52341	CYSTO W/URETER STRICTURE TX	6.11	2008	47.5				47.5	60	49							156.5	0.0658		Pre-RUC Evaluation	
		5.35	2010	2,105	45	10	15	70	45	20							135	0.0789	AUA	Post-RUC Evaluation	
52342	CYSTO W/UP STRICTURE TX	6.61	2008	60				60	65	30			1.0				175	0.0590		Pre-RUC Evaluation	
		5.85	2010	281	40	10	10	60	60	20							140	0.0700	AUA	Post-RUC Evaluation	
52343	CYSTO W/RENAL STRICTURE TX	7.31	2008	60				60	90	30			1.0				200	0.0504		Pre-RUC Evaluation	
		6.55	2010	37	45	10	10	65	60	25							150	0.0780	AUA	Post-RUC Evaluation	
52344	CYSTO/URETERO, STRICTURE TX	7.81	2008	60				60	77.5	30			1.0				187.5	0.0650		Pre-RUC Evaluation	
		7.05	2010	2,447	40	10	10	60	45	20							125	0.1200	AUA	Post-RUC Evaluation	
52345	CYSTO/URETERO W/UP STRICTURE	8.31	2008	50				50	90	30			1.0				190	0.0640		Pre-RUC Evaluation	
		7.55	2010	475	45	10	15	70	45	20							135	0.1277	AUA	Post-RUC Evaluation	
52346	CYSTOURERETO W/RENAL STRICT	9.34	2008	45				45	120	49							214	0.0603		Pre-RUC Evaluation	
		8.58	2010	144	40	10	10	60	60	20							140	0.1155	AUA	Post-RUC Evaluation	
52400	CYSTOURERETO W/CONGEN REPR	10.06	2008	90				90	60	30			1.0				261	0.0727		Pre-RUC Evaluation	
		8.69	2010	635	72.5	10	15	97.5	40	25	1.0		0.5				197.5	0.1260	AUA	Post-RUC Evaluation	
52500	REVISION OF BLADDER NECK	9.39	2008	40				40	45	35			3.0				247	0.0613		Pre-RUC Evaluation	
		8.14	2010	5,348	45	10	15	70	45	27.5			3.0				230.5	0.0582	AUA	Post-RUC Evaluation	
52640	RELIEVE BLADDER CONTRACTURE	6.89	2008	60				60	39	17			2.0				216	0.0599		Pre-RUC Evaluation	
		4.79	2010	2,217	40	10	10	60	30	20			2.0				161	0.0514	AUA	Post-RUC Evaluation	

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CPT Code	Short Descriptor	Work RVU	Last Year Before RUC Review	2008 Utilization	Pre-Service Evaluation	Pre-Service Positioning	Dress scrub and wait time	Total Pre-Time	Intra-Service Time	Immediate Post Service Time	99211	99212	99213	99214	99231	99232	99233	99234	Total Time	IWPUT	Specialty Societies	Review
53445	INSERT URO/VES NCK SPHINCTER	15.21	2009	75				75	126	24		3.0		3.0		1.0	1.0	1.0	392	0.0546		Pre-RUC Evaluation
		15.39	2010	1,949	50	15	20	85	90	25	1.0	3.0			1.0	1.0	1.0	418	0.0572	AUA	Post-RUC Evaluation	
54410	REMOVE/REPLACE PENIS PROSTH	16.48	2008	50				50	145	30		2.0	1.0	1.0					369	0.0635		Pre-RUC Evaluation
		15.18	2010	1,328	40	10	15	65	120	30	1.0	3.0			1.0	1.0	1.0	338	0.0716	AUA	Post-RUC Evaluation	
54530	REMOVAL OF TESTIS	9.31	2008	58				58	58	17		2.5		0.5		1.0	1.0	238.5	0.0673		Pre-RUC Evaluation	
		8.46	2010	1,426	57.5	10	15	82.5	60	30		2.0	1.0			0.5	0.5	246.5	0.0597	AUA	Post-RUC Evaluation	
57287	REVISE/REMOVE SLING REPAIR	11.49	2008	45				45	70	30	1.0	2.0			1.0	1.0	1.0	265	0.0656		Pre-RUC Evaluation	
		11.15	2010	1,795	40	10	10	60	60	20	1.0	3.0			1.0	1.0	1.0	244	0.0912	AUA, ACOG	Post-RUC Evaluation	
61885	INSRT/REDO NEUROSTIM ARRAY	7.37	2009	50				50	60	25		4.0		1.0	1.0	1.0	1.0	325	0.0272		Pre-RUC Evaluation	
		6.44	2010	14,358	33	3	15	51	45	20		2.0				1.0	1.0	1.0	181	0.0567	AANS/CNS	Post-RUC Evaluation
62263	EPIDURAL LYSIS MULT SESSIONS	6.41	2009	40				40	30	20	2.0			2.0		1.0	200	0.0435		Pre-RUC Evaluation		
		6.54	2010	1,269	33	10	5	48	45	20	1.0	2.0			0.5	194	0.0451	AAPM, AANS/CNS, NASS, ASA	Post-RUC Evaluation			
62350	IMPLANT SPINAL CANAL CATH	8.04	2008	70				70	60	125	4.0		1.0	2.0	1.0	1.0	1.0	487	-0.0715		Pre-RUC Evaluation	
		6.05	2010	6,416	33	10	5	48	60	20					0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation			
62355	REMOVE SPINAL CANAL CATHETER	6.60	2008	60				60	40	130	3.0		1.0		2.0	1.0	1.0	446	-0.1284		Pre-RUC Evaluation	
		4.35	2010	1,461	33	10	5	48	30	20			1.0			0.5	140	0.0429	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation		
62360	INSERT SPINE INFUSION DEVICE	3.68	2008	60				60	55	123	4.0					2.0	1.0	450	-0.1385		Pre-RUC Evaluation	
		4.33	2010	616	33	10	5	48	60	20			1.0			0.5	170	0.0211	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation		
62361	IMPLANT SPINE INFUSION PUMP	6.59	2008	60				60	60	130	4.0		1.0		2.0	1.0	1.0	482	-0.0938		Pre-RUC Evaluation	
		5.65	2010	307	33	10	5	48	60	20			1.0			0.5	170	0.0431	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation		
62362	IMPLANT SPINE INFUSION PUMP	8.58	2008	75				75	90	150	4.0					3.0	1.0	582	-0.0629		Pre-RUC Evaluation	
		6.10	2010	6,570	33	10	5	48	60	20			1.0			0.5	170	0.0506	AAPM, AANS/CNS, ASA, ISIS, NASS	Post-RUC Evaluation		
62365	REMOVE SPONE INFUSION DEVICE	6.57	2008	60				60	45	125	3.0		1.0		2.0	1.0	1.0	446	-0.1123		Pre-RUC Evaluation	
		4.65	2010	1,598	33	10	5	48	45	20			1.0			0.5	155	0.0353	AAPMR, ASA, NASS, AAPM, AANS/CNS	Post-RUC Evaluation		
62367	REVISE ARM/LEG NERVE	7.57	2008	56				56	74	19		2.0		2.5		1.0	1.0	283	0.0152		Pre-RUC Evaluation	
		7.87	2008	53				53	62	18		2.0		2.5		1.0	1.0	267	0.0245	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation	
63685	INSRT/REDO SPINE N GENERATOR	6.05	2010	9,343	33	10	5	48	60	20			1.0			0.5	170	0.0498	AAPM, AANS/CNS, NASS, ASA, ISIS	Post-RUC Evaluation		
		6.22	2009	46				46	76	18	2.5		0.5		1.0	1.0	228	0.0301		Pre-RUC Evaluation		
64708	REVISE ARM/LEG NERVE	6.36	2010	3,069	35	10	10	55	60	15	3.0	1.0				0.5	220	0.0314	AOFAS, ASSH, AAOS, ASPS	Post-RUC Evaluation		
		10.23	2008	50				50	74	21		2.5		1.0		1.0	1.0	260.5	0.0612		Pre-RUC Evaluation	
64831	REPAIR OF DIGIT NERVE	9.16	2010	972	40	10	15	65	60	15	2.0	2.0				0.5	237	0.0674	AAOS, ASPS, ASSH	Post-RUC Evaluation		
		14.43	2009	52				52	79	32		5.5	0.5			1.0	1.0	337.5	0.0730		Pre-RUC Evaluation	
65285	REPAIR OF EYE WOUND	14.71	2010	1,154	37			15	52	79	32		5.5	0.5		1.0	1.0	337.5	0.0766	AAO	Post-RUC Evaluation	

Codes to be reviewed on the Fourth Five-Year Review Agenda (52340 and 57287) and recent May 2010 Submission (61885)

23+ Hour Services to be reviewed in February, 2011 after CMS releases Final Rule decision regarding subsequent observation codes/values

\*2010 Post-RUC Review work RVWs include CMS work adjustment for elimination of consult codes and increases to EM codes, effective 1/1/10

AMA/Specialty Society RVS Update Committee  
Summary of Recommendations

February 2008

### **Ophthalmological Procedures**

Codes 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* and 68810 *Probing of nasolacrimal duct, with or without irrigation;* were identified by the RUC's Five-Year Review Identification Workgroup as having site of service anomalies in recent Medicare claims data. These services were initially priced in the facility setting, i.e. have hospital visits and full discharge management services associated with them, are now being performed in the outpatient setting more than 50% of the time, according to the Medicare Claims data. CMS had requested the RUC review these site of service anomalies.

#### **65285**

The RUC had indicated that compelling evidence was necessary if the specialty believed the site of service should remain the same for a particular service, despite recent Medicare claims data. The specialty presented a recent journal article that described the service, its complexity, and necessity of being performed in the facility setting. The specialty explained that many of the services in the Medicare data are coding errors and that the service should be removed from the ambulatory service center listing because it requires an overnight hospital stay. The RUC agreed that the procedure is typically provided within the facility inpatient setting.

**The RUC agreed with the compelling evidence presented and recommends code 65285 be removed the Site of Services Anomalies list and the physician time be reverted back to its original Harvard determined physician time. It was suggested by the specialty that this service not be included on the ASC list. In addition, a CPT Assistant article should be written to describe appropriate use of this code.**

#### **68810**

The RUC and specialty society agreed with the site of service anomaly for code 68810 and presented survey results from 33 ophthalmologists that supported the Medicare claims data. The specialty explained and the RUC agreed that reference code 68811 *Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia* (Work RVU = 2.39) was essentially the same service however typically performed on children. When code 68810 was originally reviewed by the RUC survey data indicated an overnight hospital stay, full discharge day management, and two post operative office visits. The current work relative value for the year 2008 is 2.63. Current survey data indicates the typical patient is an adult with unilateral obstruction with no overnight hospital stay, no discharge day management, and two post operative office visits.

The RUC reviewed the specialty survey results and agreed that although the hospitalization and discharge day management is not now the typical patient scenario, the two post operative visits still apply in order tend to the wound. The procedure involves poking a hole into the lacrimal sac to reconnect it the lacrimal duct. After this is done the wound tends to fibrinase over, two post operative office visits allow for the irrigation of the wound to maintain patency in the duct. With the understanding of the change in the typical site of service and that 68810 is typically performed in adults and requires less work to perform than in children, the RUC believed a value of 2.09, which is between the specialty survey median and its 25<sup>th</sup> percentile survey results, was an accurate relative work value.

The RUC also compared the physician work of code 68840 *Probing of lacrimal canaliculi, with or without irrigation* (Work RVU = 1.27, 10 minutes intra-service time) and agreed that physician work is greater than that of code 68840 as it involves more probing and an additional follow up office visit. **The RUC recommends a relative work value for code 68810 of 2.09.**

#### **Practice Expense**

There is no change to the direct practice expense inputs recommended for code 65285.

The RUC recommends an adjustment in the direct practice expense inputs for code 68810 to reflect the change in physician time and office visits associated with this service.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
65285	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue	090	14.43
68810	Probing of nasolacrimal duct, with or without irrigation;	010	2.09