AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2011

Bone Marrow Stem Cell Revisions

In October 2010, the CPT Editorial Panel split CPT code 38230 into two separate codes: 38232 *Bone marrow harvesting for transplantation; autologous* and 38230 *Bone marrow harvesting for transplantation; allogeneic*. When code 38232 was developed, and RUC reviewed in 1995, allogeneic transplants were performed the large majority of the time. Currently, the majority of transplants performed are allogeneic using bone marrow/stem cells from a related or unrelated donor. Additionally, CMS approved a change in the global period from 010 to 000, which was requested due to the fact that very few of these harvests require overnight hospitalization and physician follow-up in the days following the procedure.

38230 ***Bone marrow harvesting for transplantation; allogeneic***
The RUC reviewed and agreed with the specialty survey results from 57 hematologists for CPT code 38230. The RUC agreed with the addition of 12 minutes of pre-service positioning time to account for turning the patient over from supine to the prone position, while under general anesthesia. These additional minutes of positioning time are a RUC standard for complicated patients under general anesthesia in spine procedure. The RUC recommends pre-service time of 55 minutes, intra-service time of 90 minutes and post service time of 30 minutes. The RUC analyzed the survey's estimated physician work and agreed that the data supports the median work RVU of 4.00. To further justify this recommended value, the RUC compared the surveyed code to key reference CPT code 38205 *Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection;* allogenic (work RVU= 1.50 and intra-time= 45 minutes). The RUC agreed that while there is similar physician work involved in code 38230 and the reference code, the surveyed code should be valued greater due to longer required intra-service time, 90 minutes and 45 minutes, respectively.

The RUC also compared the surveyed code to reference code 38242 *Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions* (work RVU= 1.71 and intra-time= 30 minutes). Again, the RUC noted that while these services have similar physician work the surveyed code is the most intense procedure many of these physician do and should be valued higher due to longer required intra-service time, 90 minutes and 30 minutes, respectively. Finally, the RUC discussed the difference in work RVUs between 38232 and 38230. Even though the intra-service time between the two services are similar, the intra-service work for 38230 is more intense and stressful because it is necessary to manage the donor while performing a procedure that is not for the donor's benefit. The need to obtain more cells because of the risk of graft rejection, graft versus host disease and ABO mismatching as well as the need to accommodate cell loss at the time of removal and when the cells are processed increases the stress and intensity of the procedure. This was substantiated by the survey respondents who stated that 38230 has a higher intensity and complexity in physician work in 8 of the measures compared to 38232. **The RUC recommends a work RVU of 4.00 for CPT code 38230.**

38232 ***Bone marrow harvesting for transplantation; autologous***
The RUC reviewed and agreed with the specialty survey results from 57 hematologists for CPT code 38232. The RUC agreed with the addition of 12 minutes of pre-service positioning time to account for turning the patient over from supine to the prone position, while under general anesthesia. These additional minutes of positioning time are a RUC standard for complicated patients under general anesthesia for spine procedures. The RUC recommends pre-service time of 45 minutes, intra-service time of 90 minutes and post service time of 30 minutes. The RUC analyzed the survey's estimated physician work and agreed that the data supports the median estimated work RVU of 3.50. To further justify this recommended value, the RUC compared the surveyed code to key reference CPT code 38206 *Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous* (work RVU= 1.50 and intra-time= 35 minutes). The RUC agreed that the surveyed code should be valued greater than the reference code given the large difference in physician intra-time required to perform these procedures, 90 minutes and 35 minutes, respectively. Additionally, survey respondents rated code 38232 higher in every intensity and complexity measure compared to code 38206.

The RUC also compared the surveyed service to reference code 38242 *Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions* (work RVU= 1.71 and intra-time= 30 minutes). The specialties noted that code 38232 is a very intense service in the family of codes and should be valued greater than this reference service due to greater total time, 90 minutes and 30 minutes, respectively. Finally, to ensure that the recommended work RVU of 3.50 is appropriate for this service, the RUC noted that the current work value of 38232 is 4.85 which is for a 010 global period and includes one 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97). Subtracting the value of the post-operative visit (0.97 work RVUs) leaves 3.88 work RVUs. Given these references, the RUC agreed that the recommended median work value of 3.50 appropriately accounts for the physician work involved in this service. **The RUC recommends a work RVU of 3.50 for CPT code 38232.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense:
The RUC agreed that there were no direct inputs in the facility nor the non-facility settings as recommended by the specialty.

CPT Editorial Panel:
The RUC had a extensive discussion regarding the appropriate Evaluation and Management billing for CPT code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; per allogenic donor*. The RUC expressed concern that implementing CCI edits to preclude reporting an Evaluation and Management service on the same date of service would limit the ability for physicians to report the separately identifiable visit prior to the procedure on the same date. Given this, the RUC, and the specialty agreed, that this service should be referred back to the CPT Editorial Panel along with the family of services, CPT codes 38241 and 38242, to examine the current descriptors and descriptions of physician work to ensure these services are currently reported correctly and can be properly valued by the RUC. The specialty also mentioned that there is currently no common understanding of what services are reflected in the work of this service. CPT coding clarification and a RUC re-survey will provide for consistent reporting and appropriate valuation.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲38208	F1	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor (For diagnostic thawing and expansion of frozen cells, see 88241)	XXX	Postponement until after CPT Editorial Panel Review of 38240
▲38209	F2	thawing of previously frozen harvest, with washing, per donor	XXX	Postponement until after CPT Editorial Panel Review of 38240
▲38230	F4	Bone marrow harvesting for transplantation; allogeneic (For autologous and allogenic blood-derived peripheral stem cell harvesting for transplantation, see 38205-38206)	~~010~~ 000	4.00
●38232	F3	autologous	000	3.50
▲38240	F5	Bone marrow or blood-derived peripheral stem cell transplantation; ~~allogenic~~allogeneic	XXX	Refer to CPT Editorial Panel

Physician Payment Policy and Systems
American Medical Association
515 North State Street
Chicago, Illinois 60654
Sherry L. Smith, Director

January 10, 2011

Dear Director Smith –

During the October CPT Editorial Board Meeting, the American Society for Blood and Marrow Transplantation (ASBMT) submitted change applications for four codes:

- 38208 – Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing.
- 38209 - Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing.
- 38230 – Bone marrow harvesting for transplantation
- 38240 – Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic

Since the Editorial Board meeting, the ASBMT has engaged in conversations with CMS staff that have resulted in a decision to delay the surveys of two of these codes – 38208 and 38209 – for the time being. We anticipate additional discussions with CMS in the next few weeks and the potential need for additional edits to the codes. We will communicate this information as soon as it becomes available.

Sincerely,

Dr. James Gajewski
Chair, Reimbursement Committee
American Society of Blood and Marrow Transplantation (ASBMT)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38232 Tracking Number F3 Original Specialty Recommended RVU: **3.5**
Presented Recommended RVU: **3.5**
Global Period: 000 RUC Recommended RVU: **3.5**

CPT Descriptor: Bone marrow harvesting for transplantation, autologous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient is a 66-year-old man with multiple myeloma who is unable to have a peripheral blood stem cell collection because of the use of pre-transplant Revlimid. The patient's marrow cellularity is approximately 20%.

Percentage of Survey Respondents who found Vignette to be Typical: 54%

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? 43%

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? 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: Update history and physical to assure patient can undergo procedure. Obtain informed consent. Explain procedure to patient and family. Change into scrubs. Consult with anesthesiologist as needed.

Description of Intra-Service Work: The patient is brought to the operating room and general anesthesia is administered. Approximately 400 needle sticks are administered to collect bone marrow from the posterior iliac crest. Blood is given to the patient for red blood cell support as needed. The patient is moved to the supine position, is extubated and transferred to the recovery room.

Description of Post-Service Work: Post-operative assessment and monitoring of the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	James Gajewski, MD; Samuel Silver, MD					
Specialty(s):	American Society for Blood and Marrow Transplantation (ASBMT); American Society of Hematology (ASH)					
CPT Code:	38232					
Sample Size:	1220	**Resp N:**	57	**Response:** 4.6 %		
Sample Type:	Convenience	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	5.00	20.00
Survey RVW:	0.97	2.25	**3.50**	5.00	14.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	5.00	60.00	**90.00**	120.00	180.00

Immediate Post Service-Time:	**30.00**	
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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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); 99224 (20); 99225 (40); 99226 (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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	38232	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**33.00**	**-18.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**15.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
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** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
38206	000	1.50	**RUC Time**

CPT Descriptor Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99291	XXX	4.50	**RUC Time**	4,161,789

CPT Descriptor 1 Critical care, evaluation or management; first 30-74 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99223	XXX	3.86	**RUC Time**	5,805,837

CPT Descriptor 2 Initial hospital care, per day; 70 minutes at beside or on patient's hospital floor

Other Reference CPT Code	Global	Work RVU	Time Source
38241	XXX	2.24	**RUC Time**

CPT Descriptor Bone marrow or blood-derived peripheral stem cell transplantation, autologous

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:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 38232**	**Key Reference CPT Code:** 38206	**Source of Time** **RUC Time**
Median Pre-Service Time	45.00	40.00	
Median Intra-Service Time	90.00	35.00	
Median Immediate Post-service Time	30.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**165.00**	**95.00**	
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	3.47	3.26
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	3.63
Urgency of medical decision making	3.79	3.47
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.00	3.74
Physical effort required	4.00	3.74
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.58	3.37
Outcome depends on the skill and judgment of physician	3.95	3.63
Estimated risk of malpractice suit with poor outcome	3.63	3.21

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.47	3.21
Intra-Service intensity/complexity	3.95	3.53
Post-Service intensity/complexity	3.21	3.00

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.*

Background

At the October 2010 CPT Editorial Board meeting, CPT code 38230 (*Bone marrow harvesting for transplantation*) was split into separate codes:

- 38232: Bone marrow harvesting for transplantation; autologous

- 38230: Bone marrow harvesting for transplantation; allogeneic

When Code 38230 was developed and last reviewed (1995), the volume of allogeneic transplants was very low because most transplants were autologous; a split into autologous and allogeneic harvesting was not warranted at that time. This has changed dramatically. Currently, the majority of transplants performed are allogeneic using bone marrow/stem cells from a related or unrelated donor. This prompted the coding request to the CPT Editorial Board which resulted in a split of the current code into two.

Autologous and allogeneic bone marrow harvests differ in both patient population and physician work. The existence of two CPT codes to describe these procedures will facilitate appropriate coding and payment.

This code is now limited to autologous transplants and the vignette has been updated. The former vignette from 1995 was an uncomplicated patient receiving an autologous transplant for treatment of breast cancer. The procedure is no longer performed for this use and the current typical patients are more complicated clinically and more heavily pre-treated with chemotherapy (e.g., patients with leukemia or multiple myeloma).

Survey Notes:

1. **Typical Vignette**: 54.39% of survey respondents answered affirmatively that the presented vignette for 38232 was typical of their patients. Those who indicated that this was not a typical patient were primarily pediatricians and noted their typical patient is a small child.
2. **Global Period**: CMS approved a change in the global period from 010 to 000, which was requested due to the fact that very few of these harvests require overnight hospitalization and physician follow-up in the days following the procedure.
3. **Service Performance Rate**: Of the 57 respondents, 19 reported that they had not performed this service personally within the last calendar year. This is not surprising, nor does it affect the results of the survey. The primary reason for this is that harvesting adult bone marrow for use in transplantation is performed only when the collection of peripheral blood stem cells fails or if marrow is specifically requested due to the type of disease or age of the recipient. Approximately ten years ago, the majority of transplants were performed with cells harvested from bone marrow specimens so practically all of the respondents have performed numerous harvests in the past, but it is not surprising that some of them would not have had the need to harvest cells in this manner within the last year. This does not mean they are unfamiliar with the procedure.
4. **Survey Reference Codes**: The reference code list for this survey was limited. Transplant physicians typically specialize in Internal Medicine or Hematology/Oncology and do not perform surgical procedures outside of harvesting bone marrow or placing central lines. As we were instructed to only include codes with which the specialty members would be familiar, this greatly limited the number of similar surgical codes that could be included as points of comparison. This is also why a number of codes were included that have not previously been RUC surveyed. There are a very limited number of procedure codes performed by this specialty group and eliminating the non-RUC surveyed codes would have left only the standard office visit, inpatient care and critical care codes. The Research Committee approved the use of these codes due to the limitations of the situation.
5. **Frequency Reporting**
   The RUC database shows that orthopedic surgeons and neurosurgeons frequently utilized code 38232. This is an incorrect use of the code, which was clarified in a CPT Assistant article in June 2009. We expect the future reporting of this code to reflect the specialties of other transplant codes – Hem/Onc, Internal Medicine and Medical Oncology.

Recommendations:

We are recommending the survey median work value, the median intra and post times and are recommending a reduction in the pre-time as described below. The median RVW is 3.5 with the 25th percentile and the 75th percentile being 2.25 and 5.0 respectively. These times result in an IWPUT for 38232 of 0.023 which is extremely low for a surgical procedure requiring anesthesia.

The recommended value is supported by comparison to the key reference service and to several MPC codes. The key reference service, Code 38206 (describing blood derived stem cell harvesting) is assigned an RVW of 1.50 based on intra time of 35 minutes (1/2 that of the surveyed procedure), and pre-time of 40 minutes and post-time for 20

minutes. The intensity and complexity measures for the intra service portion of the procedure were higher for the surveyed code as were the specific measures for technical skill, physical effort, risk of malpractice and outcome being dependent on the skill and judgment of the physician. As noted earlier there were very few reference codes available for this survey and no other operating room codes that could be usefully compared to the procedure. Comparison to 38206, which was reviewed by the RUC in September 2002, strongly supports an RVU of 3.5 for 38230 because 38232 has an intra-time that is almost 3X longer (90 vs. 35 min), is much more intense and requires much more technical skill. In addition, the post service time is longer than that of 38206 (30 vs. 20 minutes) and is more intense because the patient was under anesthesia and is recovering from a surgical procedure.

CPT code 38242, Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions, which was reviewed by the RUC in April 2002 also supports the median RVU for 38232. 38242 has a work RVU of 1.71 and pre, intra and post times of 30, 30, and 20 minutes respectively.

We also note that current work RVU of 38230 is 4.85 which is for a 10 day global and include a post operative visit valued at 99213 or 0.97 work RVUs. Subtracting 0.97 from 4.85 leaves 3.88. Note that same day post op work for 38232 is still included in the code.

Therefore, the median of 3.5 is well supported by services within the same family.

We would like to specifically discuss the basis for the requested increment between 38232 and 38230 which is 0.5 works RVU. Even though the intraservice times for 38232 and 38230 in the surveys were similar, the intra-service work of 38230 is more intense and stressful because it is necessary to manage the donor while performing a procedure that is NOT for the donor's benefit. In fact, while performing the procedure and collecting marrow, it is the recipient's needs that must be kept in mind. The need to obtain more cells because of the risk of graft rejection, graft vs. host disease and ABO mismatching as well as the need to accommodate cell loss at the time of removal and when the cells are processed increases the stress and intensity of the procedure. Additionally, we believe that the respondents may have underestimated the intra-service time for 38230 because allogeneic donors are either unrelated donors, mismatched related donors, or matched sibling donors which, as described above, mean a much higher cell dose from the donor is required, thus requiring longer operative time for harvesting than with an autologous harvest. Therefore, we are unclear as to why the survey times came out similarly.

With respect to services outside of this family, we reviewed the following codes which support our request:
000 Globals - all have been reviewed by the RUC.

- 36556, Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older. This 000 global code has a work RVU of 2.5 with pre, intra and post times of 25, 15 and 10 minutes respectively. This is an MPC code.
- 32603, Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy. This 000 global code has a work RVU of 7.8 with pre, intra and post times of 83, 90 and 120 minutes respectively. This is an MPC code.
- 43240, Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst. This 000 global code has a work RVU of 6.85 and pre, intra and post times of 20, 90 and 20 minutes respectively. This is an MPC code.
- 45380, Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple. This code has a work RVU of 4.43 and pre, intra and post times of 45, 51.5 and 22 minutes respectively. This code is an MPC code.
- 31638, Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required). This code has a work RVU of 4.88 and pre, intra and post times of 50, 60 and 30 minutes respectively.
- 52001, Cystourethroscopy with irrigation and evacuation of multiple obstructing clots. This code has a work RVU of 5.44 and pre, intra and post times of 50, 60 and 20 minutes respectively.

XXX Globals - all have been reviewed by the RUC.

- 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; a comprehensive examination; Medical decision making of

high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family. This XXX global code has a work RVU of 3.17 and pre, intra and post times of 7, 45 and 15 minutes respectively. This is an MPC code.

- 99223, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. This XXX global code has a work RVU of 3.86 and pre, intra and post times of 15, 55 and 20 minutes respectively. This code has an IWPUT of 0.05559 which is about two and one half times the requested IWPUT for 38230. This is an MPC code.
- 99327, Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver. This XXX global code has a work RVU of 3.46 and pre, intra and post times of 15, 60 and 25 minutes respectively
- 95978, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour. This XXX global code has a work RVU of 3.5 and pre, intra and post times of 5, 60 and 5 minutes respectively.
- 91110, Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report. This code has a work RVU of 3.64 and pre, intra and post times of 5, 80 and 15 minutes respectively.
- 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes. This code has a work RVU of 4.5 and pre, intra and post times of 15, 40 and 15 minutes respectively. Note that this code has an IWPUT of 0.0957 which is about four times the recommended IWPUT for 38230.

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) 38230

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 Hematology/Oncology How often? Sometimes

Specialty Medical Oncology How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1200
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. There are an estimated 12,000 autologous transplants per year in the United States and an estimated 10% of these utilize bone marrow as the cell source.

Specialty Hematology/Oncology Frequency 800 Percentage 66.66 %

Specialty Medical Oncology Frequency 200 Percentage 16.66 %

Specialty Internal Medicine Frequency 200 Percentage 16.66 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 225
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated split between 28230 and 3823X1

Specialty Hematology/Oncology Frequency 150 Percentage 66.66 %

Specialty Medical Oncology Frequency 38 Percentage 16.88 %

Specialty Internal Medicine Frequency 37 Percentage 16.44 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 38230

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38230 Tracking Number F4 Original Specialty Recommended RVU: **4.0**
Presented Recommended RVU: **4.0**
Global Period: 000 RUC Recommended RVU: **4.0**

CPT Descriptor: Bone marrow harvesting for transplantation, allogeneic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient is a 65-year-old woman with aplastic anemia who has failed antithymocyte immunoglobulin therapy with cyclosporine. The patient has a sibling donor who is fully HLA matched.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

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? 38%

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? 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: Update history and physical to assure donor can undergo procedure. Obtain informed consent. Explain procedure to donor and family. Change into scrubs. Consult with anesthesiologist as needed.

Description of Intra-Service Work: The donor is brought to the operating room and general anesthesia is administered. Approximately 400 needle sticks are administered to collect bone marrow from the posterior iliac crest. Blood is given to the donor for red blood cell support and as needed irradiated packed RBCs are provided. The donor is moved to the supine position, is extubated and transferred to the recovery room.

Description of Post-Service Work: Post-operative assessment and monitoring of the donor.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011				
Presenter(s):	James Gajewski, MD; Samuel Silver, MD				
Specialty(s):	American Society for Blood and Marrow Transplantation (ASBMT); American Society of Hematology (ASH)				
CPT Code:	38230				
Sample Size:	1224	**Resp N:**	47	**Response:** 3.8 %	
Sample Type:	Convenience	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	9.00	30.00
Survey RVW:	1.50	3.09	**4.00**	5.00	14.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	40.00	60.00	**90.00**	120.00	180.00

Immediate Post Service-Time:	**30.00**	
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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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); 99224 (20); 99225 (40); 99226 (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: 3 -FAC Straightforward Patient/Difficult Procedure

CPT Code:	38230	**Recommended Physician Work RVU: 4.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**20.00**	**33.00**	**-13.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**15.00**	**5.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
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** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
38205	000	1.50	**RUC Time**

CPT Descriptor Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99291	XXX	4.50	**RUC Time**	4,161,789

CPT Descriptor 1 Critical care, evaluation or management; first 30-74 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99223	XXX	3.86	**RUC Time**	5,805,837

CPT Descriptor 2 Initial hospital care, per day; 70 minutes at beside or on patient's hospital floor

Other Reference CPT Code	Global	Work RVU	Time Source
38241	XXX	2.24	**RUC Time**

CPT Descriptor Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic

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:** 31.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 38230**	**Key Reference CPT Code:** 38205	**Source of Time** **RUC Time**
Median Pre-Service Time	55.00	38.00	
Median Intra-Service Time	90.00	45.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	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 Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**175.00**	**113.00**	
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	3.60	3.67
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	4.00
Urgency of medical decision making	3.93	3.93
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.13	4.07
Physical effort required	4.33	3.80
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.80	3.80
Outcome depends on the skill and judgment of physician	4.07	4.00
Estimated risk of malpractice suit with poor outcome	3.87	3.73

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.47	3.53
Intra-Service intensity/complexity	3.73	3.67
Post-Service intensity/complexity	3.40	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.*

Background

At the October 2010 CPT Editorial Board meeting, CPT code 38230 (*Bone marrow harvesting for transplantation*) was split into separate codes:

- 38232: Bone marrow harvesting for transplantation; autologous

- 38230: Bone marrow harvesting for transplantation; allogeneic

When Code 38230 was developed and last reviewed (1995), the volume of allogeneic transplants was very low because most transplants were autologous; a split into autologous and allogeneic harvesting was not warranted at the time. This has changed dramatically. Currently, the majority of transplants performed are allogeneic using bone marrow/stem cells from a related or unrelated donor. This prompted the coding request to the CPT Editorial Board which resulted in a split of the current code into two. Autologous and allogeneic bone marrow harvests differ in both patient population and physician work. The existence of two CPT codes to describe these procedures will facilitate appropriate coding and payment.

Allogeneic donors are either unrelated donors, mismatched related donors, or matched sibling donors. If there is a significant HLA mismatch between donor and recipient, marrow harvest is preferred to peripheral harvest because of less recipient complications. In addition, marrow donation is often safer for the donor if he/she has major cardiovascular co-morbidities. However, a high cell dose from the donor is required, thus requiring longer operative time for harvesting than with an autologous harvest.

Survey Notes:

1. **Typical Vignette**: 76.6% of survey respondents answered affirmatively that the presented vignette for 38230 was typical of their patients. Those who indicated that this was not a typical patient were primarily pediatricians and noted their typical patient is a small child.
2. **Global Period**: CMS approved a 000 global period to mirror the change request submitted for 38232 from a 10 day to a 000 day global service. The change in the global period from 010 to 000 was requested due to the fact that very few of these harvests require overnight hospitalization and physician follow-up in the days following the procedure.
3. **Service Performance Rate**: Of the 47 respondents, 9 reported that they had not performed this service personally within the last calendar year. This is not surprising, nor does it affect the results of the survey. The primary reason for this is that harvesting adult bone marrow for use in transplantation is performed only when the collection of peripheral blood stem cells fails or if marrow is specifically requested due to the type of disease or age of the recipient. Approximately ten years ago, the majority of transplants were performed with cells harvested from bone marrow specimens so practically all of the respondents have performed numerous harvests in the past, but it is not surprising that some of them would not have had the need to harvest cells in this manner within the last year. This does not mean they are unfamiliar with the procedure.
4. **Survey Reference Codes:** The reference code list for this survey was limited. Transplant physicians typically specialize in Internal Medicine or Hematology/Oncology and do not perform surgical procedures outside of harvesting bone marrow or placing a central line. As we were instructed to only include codes with which the specialty members would be familiar, this greatly limited the number of similar surgical codes that could be included as points of comparison. This was why a number of codes were included that have not previously been RUC surveyed. There are a very limited number of procedure codes performed by this specialty group and eliminating the non-RUC surveyed codes would have left only the standard office visit, inpatient care and critical care codes. The Research Committee approved the use of these codes due to the limitations of the situation.
5. **Frequency Reporting**
   The RUC database shows that orthopedic surgeons and neurosurgeons frequently utilized code 38230. This is an incorrect use of the code, which was clarified in a CPT Assistant article in June 2009. We expect the future reporting of this code to reflect the specialties of other transplant codes – Hem/Onc, Internal Medicine and Medical Oncology.

Recommendations:

We are recommending the work value and the intra and post times based on the median survey data and are recommending a reduction in pre-service time as discussed below. The median RVW is 4.0 with the 25th percentile and the 75th percentile being 3.09 and 5.0 respectively. The recommended times result in an IWPUT for 38230 of 0.028 which is extremely low for a surgical procedure requiring anesthesia.

The recommended value is supported by comparison to the key reference service and to several MPC codes. The key reference service, Code 38205 is assigned an RVW of 1.50 based on intra time of 45 minutes (1/2 that of the surveyed procedure) and pre and post times of 38 and 30 minutes respectively. The intensity and complexity measures for the procedure were higher for the surveyed code as were the specific measures for technical skill, physical effort, risk of malpractice and outcome being dependent on the skill and judgment of the physician. As noted earlier, there were very few reference codes available for this survey and no other operating room codes that could be usefully compared to the procedure.

Comparison to 38205, which was reviewed by the RUC in September 2002, strongly supports an RVU of 4.0 for 38230 because 38230 has an intra-time that is 2X longer (90 vs. 45 min), is much more intense and requires much more technical skill. In addition the post service time, while similar in length to 38205, is more intense because the patient was under anesthesia and is recovering from a surgical procedure.

CPT code 38242, Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions, which was reviewed by the RUC in April 2002 also supports the median RVU for 38230. 38242 has a work RVU of 1.71 and pre, intra and post times of 30, 30, and 20 minutes respectively. The intra time of 38230 is three times longer than that of 38242.

We also note that current work RVU of 38230 is 4.85 which is for a 10 day global and include a post operative visit valued at 99213 or 0.97 work RVUs. Subtracting 0.97 from 4.85 leaves 3.88. Note that same day post op work for 38230 is included in this code.

Therefore, the median of 4.0 is well supported by services within the same family.

Below we discuss a number of codes that support our work RVU request. However, we would like to specifically discuss the basis for the requested increment between this code and 38232, which is 0.5 work RVUs. Even though the intraservice times for 38232 and 38230 in the surveys were similar, the intra-service work of 38230 is more intense and stressful because it is necessary to manage the donor while performing a procedure that is NOT for the donor's benefit. In fact, while performing the procedure and collecting marrow, it is the recipient's needs that must be kept in mind. The need to obtain more cells because of the risk of graft rejection, graft vs. host disease and ABO mismatching as well as the need to accommodate cell loss at the time of removal and when the cells are processed increases the stress and intensity of the procedure. Additionally, we believe that the respondents may have underestimated the intra-service time for 38230 because allogeneic donors are either unrelated donors, mismatched related donors, or matched sibling donors which, as described above, mean a much higher cell dose from the donor is required, thus requiring longer operative time for harvesting than with an autologous harvest. Therefore, we are unclear as to why the survey times came out similarly.

With respect to services outside of this family, we reviewed the following codes which support our request:

000 Globals - all have been reviewed by the RUC.

- 36556, Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older. This 000 global code has a work RVU of 2.5 with pre, intra and post times of 25, 15 and 10 minutes respectively. This is an MPC code.
- 32603, Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy. This 000 global code has a work RVU of 7.8 with pre, intra and post times of 83, 90 and 120 minutes respectively. This is an MPC code.
- 43240, Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst. This 000 global code has a work RVU of 6.85 and pre, intra and post times of 20, 90 and 20 minutes respectively. This is an MPC code.
- 45380, Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple. This code has a work RVU of 4.43 and pre, intra and post times of 45, 51.5 and 22 minutes respectively. This code is an MPC code.

- 31638, Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required). This code has a work RVU of 4.88 and pre, intra and post times of 50, 60 and 30 minutes respectively.
- 52001, Cystourethroscopy with irrigation and evacuation of multiple obstructing clots. This code has a work RVU of 5.44 and pre, intra and post times of 50, 60 and 20 minutes respectively.

XXX Globals - all have been reviewed by the RUC.

- 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; a comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family. This XXX global code has a work RVU of 3.17 and pre, intra and post times of 7, 45 and 15 minutes respectively. This is an MPC code.
- 99223, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. This XXX global code has a work RVU of 3.86 and pre, intra and post times of 15, 55 and 20 minutes respectively. This code has an IWPUT of 0.05559 which is about two and one half times the requested IWPUT for 3823X1. This is an MPC code.
- 99327, Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver. This XXX global code has a work RVU of 3.46 and pre, intra and post times of 15, 60 and 25 minutes respectively
- 95978, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour. This XXX global code has a work RVU of 3.5 and pre, intra and post times of 5, 60 and 5 minutes respectively.
- 91110, Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report. This code has a work RVU of 3.64 and pre, intra and post times of 5, 80 and 15 minutes respectively.
- 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes. This code has a work RVU of 4.5 and pre, intra and post times of 15, 40 and 15 minutes respectively. Note that this code has an IWPUT of 0.0957 which is about four times the recommended IWPUT for 3823X1.

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) 38230

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 Hematology/Oncology How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Pediatrics How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1800
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. There are approximately 6,000 allogeneic transplants per year in th United States and an estimated 30% of those utilize bone marrow for the cell source.

Specialty Hematology/Oncology	Frequency 1000	Percentage 55.55 %
Specialty Medical Oncology	Frequency 400	Percentage 22.22 %
Specialty Internal Medicine	Frequency 400	Percentage 22.22 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. With the split in codes, we estimate that 400 services will be reported in the 3823X1 code.

Specialty Hematology/Oncology	Frequency 200	Percentage 50.00 %
Specialty Medical Oncology	Frequency 100	Percentage 25.00 %
Specialty Internal Medicine	Frequency 100	Percentage 25.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 38230

	A	B	C	J	K	L	M	N	O
1	**AMA/Specialty Society RVS Update Committee Recomm**			**F3**		**F4**		**F5**	
2	**Meeting Date: February 2011**			**38232**		**38230**		**38240**	
3	**Bone Marrow Stem Cell Revisions**			Bone marrow harvesting for transplantation; autologous		F3 Bone marrow harvesting for transplantation; allogeneic		Bone marrow or blood-derived peripheral stem cell transplantation; per allogenic donor	
4	**LOCATION**	**Code**	**Staff Type**	**Non-Facility**	**Facility**	**Non-Facility**	**Facility**	**Non-Facility**	**Facility**
5	**GLOBAL PERIOD**			000	000	000	000	XXX	XXX
6	**TOTAL CLINICAL LABOR TIME**			**n/a**	**0**	**n/a**	**0**	**n/a**	**0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**n/a**	**0**	**n/a**	**0**	**n/a**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**n/a**	**0**	**n/a**	**0**	**n/a**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**			**n/a**	**0**	**n/a**	**0**	**n/a**	**0**
10	**PRE-SERVICE**								
11	**Start: Following visit when decision for surgery or procedure made**								
12	Complete pre-service diagnostic & referral forms			**0**	**0**	**0**	**0**	**0**	**0**
13	Coordinate pre-surgery services			**0**	**0**	**0**	**0**	**0**	**0**
14	Schedule space and equipment in facility			**0**	**0**	**0**	**0**	**0**	**0**
15	Provide pre-service education/obtain consent			**0**	**0**	**0**	**0**	**0**	**0**
16	Follow-up phone calls & prescriptions			**0**	**0**	**0**	**0**	**0**	**0**
17	Other Clinical Activity:coordination of care			**0**	**0**	**0**	**0**	**0**	**0**
18	**End:When patient enters office/facility for surgery/procedure**								
19	**SERVICE PERIOD**								
20	**Start: When patient enters site for procedure: Services Prior to Procedure**								
39									
40	Discharge day management			**0**	**0**	**0**	**0**	**0**	**0**
42	**End: Patient leaves office**								
43	**POST-SERVICE Period**								
44	**Start: Patient leaves office/facility**								
45	Conduct phone calls/call in prescriptions								
46	*Office visits:*								
47	*List Number and Level of Office Visits*								
48	99211 16 minutes		16						
49	99212 27 minutes		27						
50	99213 36 minutes		36						
51	99214 53 minutes		53						
52	99215 63 minutes		63						
53	Other								
54	***Total Office Visit Time***			**0**	**0**	**0**	**0**	**0**	**0**
55	***Other Total:***								
56	**End: with last office visit before end of global period**								
57	**MEDICAL SUPPLIES**	**Code**	**Unit**						
58	None								
59									
60	**Equipment**	**Code**							
61	None								
62									

AMA/Specialty Society RVS Update Committee Summary of Recommendations
April 2011

Collagenase Injection

In February 2011, the CPT Editorial Panel created two new codes to describe a new technique for treating Dupuytren's contracture by injecting an enzyme (collagenase) into the Dupuytren's cord in order for full finger extension and manipulation.

20527 ***Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)***
The RUC reviewed the survey results from 30 hand, plastic, and orthopaedic surgeons for code 20527 and agreed with the specialty societies that the survey 25th percentile work RVU of 1.00 appropriately accounts for the physician work required to perform this service. The RUC compared this new injection to the survey's key reference code 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU = 0.94). The specialty society explained that multiple injections (typically 3 times) at the site are performed, and extreme care is exercised so that unintended structures (ie, nerves, tendons) are not exposed to the enzyme and destroyed. The physician ensures the enzyme is only injected into the Dupuytren's cord, as it is highly destructive. Given this increased intensity, the surveyed code should be valued slightly greater than the reference code. In addition, the RUC compared 20527 to the CPT code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75) with the understanding that the new code is much more complex, intense, and carries more risk, as the injection of a steroid into a tendon does not include the complexity of avoiding structures to the degree that injecting collagenase includes. The RUC agreed with the specialty's survey results, and recommendation in comparison to CPT codes 20526 and 20551. **The RUC recommends the survey 25th percentile work RVU of 1.00 for CPT code 20527.**

26341 ***Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord***
The RUC reviewed the survey results from 30 hand, plastic, and orthopaedic surgeons for code 26341 and agreed with the specialty societies that the survey 25th percentile work RVU of 1.66 appropriately accounts for the physician work required to perform this service. This service is performed the day after the injection of the enzyme. The patient's hand is swollen from the injection and examined to assess for nerve or tendon injury. The hand is prepped, local or regional block anesthesia is applied and the finger is manipulated into full extension assuring disruption of the Dupuytren's cord. Multiple manipulations at 10 minute intervals with a maximum of three manipulations may be required to obtain full extension. The specialty and the RUC considered what the total work would be if the work of Evaluation and Management services were reported, one for the day of the procedure and one for the follow-up visit. The RUC concurred with the specialty that the total work of 26341 would be between two 99213 (RVW = 1.94) and one 99213 plus one 99212 (RVW=1.45). Due to the fact the patient was seen the previous day, the specialty reduced the pre-service evaluation time in Pre-time package 6 (office procedure with anesthesia) by 7 minutes (equal to the survey median time).

The RUC also compared the work of new code 26341 to that of 11421 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm* (work RVU = 1.47) and agreed that the work of this new service required more technical expertise and work effort. **The RUC recommends the survey 25th percentile work RVU of 1.66 for CPT code 26341.**

Practice Expense: The RUC carefully reviewed the direct practice expense inputs recommended by the specialty societies and approved the clinical labor, supplies and equipment associated with these services.

CPT Code (●New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Musculoskeletal System** **General** **Introduction or Removal**				
20550		Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")		0.75
●20527	Q1	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture) (For manipulation of palmar fascial cord (ie, Dupuytren's cord) post enzyme injection (eg, collagenase), use 26341)	000	1.00
Hand and Fingers **Incision**				
E 26045		Fasciotomy, palmar (eg, Dupuytren's contracture); open, partial (For palmar fasciotomy by enzyme injection (eg, collagenase), see 20527, 26341) (For fasciectomy, see 26121-26125)	090	5.73 (No Change)
Excision				

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
26123		Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)	090	10.88 (No Change)
E +26125		each additional digit (List separately in addition to code for primary procedure) (Use 26125 in conjunction with 26123) (For palmar fasciotomy by enzyme injection (eg, collagenase), see 20527, 26341) (For fasciotomy, see 26040, 26045)	ZZZ	4.60 (No Change)
Repair, Revision, and/or Reconstruction				
26340		Manipulation, finger joint, under anesthesia, each joint	090	2.80 (No Change)
●26341	Q2	Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord (For enzyme injection (eg, collagenase), palmar fascial cord (eg, Dupuytren's contracture), use 20527) (Report custom orthotic fabrication/application separately)	010	1.66

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:20527 Tracking Number Q1 Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: 000 RUC Recommended RVU: **1.00**

CPT Descriptor: Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male with Dupuytren's contracture presents with a cord resulting in a fixed flexion contracture of the metacarpophalangeal or proximal interphalangeal joint. The patient undergoes enzyme (eg, collagenase) injection into the cord. [Note: Manipulation of palmar fascial cord is reported separately.]

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? 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. Verify that all required instruments and supplies are available. Prepare the injection. Assist with appropriate positioning to expose and stabilize the injection site. Prep the injection site. Scrub and glove. Perform "time out."

Description of Intra-Service Work: The contracted fascial cord is injected in three separate but proximate locations with enzyme. During the course of the injection, appropriate needle placement is confirmed by assessing neural function and tendon flexion. Great care is taken to avoid injection into the adjacent neurovascular bundles and flexor tendons.

Description of Post-Service Work: A bulky hand dressing is applied. The patient is observed for potential drug reactions. Instructions, warnings, and restrictions (eg, activity) are provided to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Daniel Nagle, MD, FACS; Anne Miller, MD; Melissa Crosby, MD, FACS; Deborah Bash, MD, FACS; William Creevy, MD		
Specialty(s):	hand surgery, plastic surgery, orthopaedic surgery		
CPT Code:	20527		
Sample Size: 267	**Resp N:** 30	**Response:** 11.2 %	
Sample Type:	Convenience **Additional Sample Information:** sent to random sample of hand surgeons, plastic surgeons, and orthopaedic surgeons trained and experienced per manufacturer database		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	3.00	**7.00**	13.00	35.00
Survey RVW:	0.80	1.00	**1.23**	1.50	1.50
Pre-Service Evaluation Time:			**21.00**		
Pre-Service Positioning Time:			**2.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	2.00	5.00	**5.00**	10.00	10.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	20527	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**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** 99217x **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**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
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.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20551	000	0.75	**RUC Time**	217,795

CPT Descriptor 1 Injection(s); single tendon origin/insertion

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31575	000	1.10	**RUC Time**	557,616

CPT Descriptor 2 Laryngoscopy, flexible fiberoptic; diagnostic

Other Reference CPT Code	Global	Work RVU	Time Source
		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: 11 **% of respondents:** 36.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 20527**	**Key Reference CPT Code:** 20526	**Source of Time** **RUC Time**
Median Pre-Service Time	8.00	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	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**18.00**	**16.00**	

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	2.64	2.55
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.09	2.45
Urgency of medical decision making	2.00	2.00
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.91	2.45
Physical effort required	2.73	1.73
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.00	2.09
Outcome depends on the skill and judgment of physician	3.82	2.36
Estimated risk of malpractice suit with poor outcome	3.82	2.27

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.64	2.00
Intra-Service intensity/complexity	3.55	2.82
Post-Service intensity/complexity	2.45	1.91

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.*

Background information for key reference code 20526
A series of new/revised injection codes (20526, 20550, 20551, 20552, 20553) were reviewed by the RUC in April 2002. The consensus group of specialties, including: neurology, orthopaedic surgery, physiatry, rheumatology, podiatry, anesthesiology, plastic surgery, hand surgery, and spine surgery presented information regarding ranking of total physician work, taking into account relative intensity and complexity, and recommending work RVUs that would be work neutral. Key reference code 20526 was deemed to be the most complex/intense injection because of the increased risk/intensity/complexity when injecting near the median nerve.

Recommendation
The consensus panel believes the risk, intensity, and complexity for new code 205X1 is slightly higher than for key reference code 20526. Collagenase is a destructive enzyme that will be injected to dissolve/disrupt the Dupuytren's cord. Multiple injections at the site are performed and extreme care must be exercised so that unintended structures are not exposed to the enzyme (ie, nerves, tendons) and destroyed.

Compared with the MPC injection code 20551 (*Injection(s); single tendon origin/insertion*), new code 205X1 is more complex, intense and carries more risk. Injecting a steroid into a tendon does not include the complexity of avoiding structures to the degree that injecting collagenase includes. In previous ranking of injection codes, the specialties, the RUC, and CMS agreed that 20526 was more total work than 20551.

Based on relative ranking of the injections codes, where 205X1 is slightly more complex and carries more immediate risk compared with 20526, we recommend the survey median RVU of 1.00.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed)
20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
26989 Unlisted procedure, hands or fingers

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 hand surgery How often? Sometimes

Specialty plastic surgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

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. Since the FDA approval of collagenase in February of 2010 approximately 4500 injections have been administered through December 31, 2010. Based on insurance coordination for sold units, commercial insurance versus Medicare is evenly split (50% each).

Specialty hand surgery Frequency 2250 Percentage 50.00 %

Specialty plastic surgery Frequency 1125 Percentage 25.00 %

Specialty orthopaedic surgery Frequency 1125 Percentage 25.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,250
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 insurance coordination for sold units, commercial insurance versus Medicare is evenly split (50% each).

Specialty hand surgery Frequency 1125 Percentage 50.00 %

Specialty plastic surgery Frequency 562 Percentage 24.97 %

Specialty orthopaedic surgery Frequency 562 Percentage 24.97 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20526

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:26341 Tracking Number Q2 Original Specialty Recommended RVU: **1.66**
Presented Recommended RVU: **1.66**
Global Period: 010 RUC Recommended RVU: **1.66**

CPT Descriptor: Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male with Dupuytren's contracture who underwent enzyme (eg, collagenase) injection into a palmar fascial cord (separately reported) the previous day presents for manipulation of the contracted finger. [Note that fabrication and application of an orthosis would be reported separately.]

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

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 100%

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. Review risks and complications. Obtain consent. Remove the dressing and examine the injection site and contracture. Prep the hand. Scrub and glove. Administer local anesthetic. Perform "time out."

Description of Intra-Service Work: The wrist is held in flexion while gentle but firm traction is placed across the contracted finger until the rupture of the fascial cord is felt and the digit fully extends. This process can be repeated two more times at 10-minute intervals if full extension is not initially achieved. Once the digit is fully extended, the tendon function is evaluated.

Description of Post-Service Work: Cutaneous disruption, if present is dressed. Instructions on care and restrictions (eg, bathing, activity) are provided to the patient. An order is written for a hand-based splint holding the involved digit in extension. One week later, the patient's hand is examined and resolution of contracture assessed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Daniel Nagle, MD, FACS; Anne Miller, MD; Melissa Crosby, MD, FACS; Deborah Bash, MD, FACS; William Creevy, MD		
Specialty(s):	hand surgery, plastic surgery, orthopaedic surgery		
CPT Code:	26341		
Sample Size: 267	**Resp N:** 30	**Response:** 11.2 %	
Sample Type:	Convenience **Additional Sample Information:** sent to random sample of hand surgeons, plastic surgeons, and orthopaedic surgeons trained and experienced per manufacturer database		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	4.00	**7.00**	14.00	50.00
Survey RVW:	1.50	1.66	**2.50**	3.00	4.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**10.00**		
Intra-Service Time:	5.00	10.00	**10.00**	15.00	30.00

Immediate Post Service-Time:	**10.00**	
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** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	26341	**Recommended Physician Work RVU: 1.66**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**17.00**	**-7.00**
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:		**10.00**		

Immediate Post Service-Time:	**10.00**	
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** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 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**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
10061	000	2.45	**Harvard Time**

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

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11421	000	1.47	**RUC Time**	39,777

CPT Descriptor 1 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11423	000	2.06	**RUC Time**	18,692

CPT Descriptor 2 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
26010	000	1.59	**Harvard Time**

CPT Descriptor Drainage of finger abscess; simple

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:** 23.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 26341**	**Key Reference CPT Code:** 10061	**Source of Time RUC Time**
Median Pre-Service Time	16.00	8.00	
Median Intra-Service Time	10.00	27.00	
Median Immediate Post-service Time	10.00	8.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	16.0	16.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**52.00**	**78.00**
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	3.14	2.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.33
Urgency of medical decision making	2.00	2.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.43	2.67
Physical effort required	2.71	2.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.43	2.17
Outcome depends on the skill and judgment of physician	3.71	2.67
Estimated risk of malpractice suit with poor outcome	3.43	2.33

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.57	2.00
Intra-Service intensity/complexity	3.43	3.33
Post-Service intensity/complexity	3.14	2.50

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 work related to new code 263X1 can be broken into two components: the manipulation procedure to disrupt the fascial cord and the follow-up office visit. On the day of the manipulation procedure, dressings are removed from the typically swollen hand (related to the collagenase injection given the day before) and the hand is examined to assess for nerve or tendon injury. Due to the fact the patient was seen the previous day, we are reducing the pre-service evaluation time in Pre-time package 6 by 7 minutes (equal to the survey median time). After the exam and discussion with the patient regarding the procedure, anesthesia is administered, most often local infiltration in the area of the cord to be manipulated. Alternatively, some surgeons perform a nerve block at the median and/or ulnar nerve. Anesthesia will be determined on a patient-by-patient basis depending on the severity of contracture and tolerance for pain. When the anesthetic has taken effect, the hand will be positioned and the finger gently extended to disrupt the cord. If full extension is not achieved, the process can be repeated in 10-minute intervals. Cutaneous rupture may occur, more often for PIP contractures. When successful cord disruption is attained, a temporary dressing is applied, the patient is provided instructions on daily care (eg, activity, bathing) and use of a splint. An order for fabrication of an orthotic to maintain extension of finger is written. If swelling and pain are severe, orders are written for an anti-inflammatory and/or pain medication. At the follow-up visit, the patient's hand is examined and resolution of contracture assessed.

The consensus panel reviewing the survey data does not believe the median RVW and comparison to the key reference code 10061 accurately reflect the work of 263X1. For information, we note that key reference code is currently Harvard based in the RUC database, however, the RUC reviewed 10061 in 2010 as part of the 4th 5YR. The table below shows the current RUC database information and the RUC recommendation submitted to CMS.

Source	CPT	IWPUT	MED	Time	EVAL	POSIT	SDW	MED	POST	-38	-12
KEY REF-Hvd	10061	0.036	2.45	78	8			27	8	0.5	1
KEY REF-RUC 2010	10061	0.039	2.45	83	8	3	5	25	10		2

Based on the RUC survey data and an expert panel discussion with surgeons familiar with this procedure, we are recommending the survey 25th percentile work RVU of 1.66. In support of this recommendation, we considered what the total work would be if the work were compared to that associated with E/M codes, one for the day of the procedure and one for the follow-up visit. We estimate the work would be **between** 2 x 99213 (RVW = 1.94) **and** 1x99213 plus 1x99212 (RVW=1.45). While we are recommending 99212 for the follow-up visit, we note that our RUC survey indicated a near equal split between the two codes 99213 and 99212 for the follow-up visit, but leaned toward 99213. Further, for the work related to the day of the procedure, we believe the administration of anesthesia and total time spent face-to-face with the patient is slightly more work than that of a 99213 given the fact the manipulation can lead to neuropraxia as well as cutaneous disruption. Based on this discussion, we believe the 25th percentile work RVU is supported as it relates to reporting E/M work. This value is also supported by the relative comparable total work and time required for another reference code familiar to hand surgeons, 26010.

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. Custom fabrication and application of an orthotic will be performed by a PT or OT and reported separately.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 26989 or 26340

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 hand surgery How often? Sometimes

Specialty plastic surgerey How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

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. Since the FDA approval of collagenase in February of 2010 approximately 4500 injections have been administered through December 31, 2010. Based on insurance coordination for sold units, commercial insurance versus Medicare is evenly split (50% each).

Specialty hand surgery Frequency 2250 Percentage 50.00 %

Specialty plastic surgery Frequency 1125 Percentage 25.00 %

Specialty orthopaedic surgery Frequency 1125 Percentage 25.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,250
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 insurance coordination for sold units, commercial insurance versus Medicare is evenly split (50% each).

Specialty hand surgery Frequency 1125 Percentage 50.00 %

Specialty plastic surgery Frequency 562 Percentage 24.97 %

Specialty orthopaedic surgery Frequency 562 Percentage 25.00 %

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

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 20526

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

CPT Long Descriptor:
Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)

Global Period: 000

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of surgeons familiar with the procedure compared the necessary practice expense details in comparison to a similar procedure (20526) to develop the recommendations presented.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:
Code 20526 was chosen as a comparison code as it is a similar injection code. Key differences are related to the difference between the injected drugs (collagenase versus steroid).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Complete pre-service diagnostic & referral forms. Insurance approval for injection of collagenase is a time consuming undertaking by clinical staff, similar to prior approval for surgery. Clinical staff will complete pre-procedure forms to submit to insurer, discuss coordination of benefits especially with respect to the expensive drug, and coordinate ordering and shipment of the medication from a specialty pharmacy. We therefore are recommending the maximum allowed time of 5 minutes to account for the numerous phone calls and submission of forms.

Provide pre-service education/obtain consent. There is typically at least several weeks lapse of time between patient decision to proceed with the injection and approval and scheduling of the procedure. After payer approval, clinical staff will call the patient to confirm the scheduled appointments and review the protocol and confirm the patient still wants to proceed with the injection and necessary follow-up. We are recommending 3 minutes (a phone call) for this activity.

Intra-Service Clinical Labor Activities:
Clinical staff will greet the patient and ensure appropriate medical records are available. The procedure supplies are assembled and procedure room prepared. Clinical staff will assist the surgeon 100% of the time during the injection. Post-injection, clinical staff will spend 10 minutes with the patient – this time has been distributed between monitoring the patient, cleaning the room (while monitoring the patient), and reviewing instructions until next visit.

Post-Service Clinical Labor Activities:
No time has been allotted for this service period.

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

CPT Long Descriptor:
Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)

Global Period: 000

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of surgeons familiar with this procedure compared the necessary practice expense details with a similar procedure (20526) to develop the recommendations presented. We would like to note that this procedure is expected to rarely be provided in a facility setting.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:
Code 20526 was chosen as a comparison code as it is a similar injection code. Key differences are related to the difference between the injected drugs (collagenase versus steroid).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
Complete pre-service diagnostic & referral forms. Insurance approval for injection of collagenase is a time consuming undertaking by clinical staff, similar to prior approval for surgery. Clinical staff will complete pre-procedure forms to submit to insurer, discuss coordination of benefits especially with respect to the expensive drug, and coordinate ordering and shipment of the medication from a specialty pharmacy. We therefore are recommending the maximum allowed time of 5 minutes to account for the numerous phone calls and submission of forms.

Schedule space and equipment in facility. When performed in a facility setting, clinical staff will need to schedule the space and arrange for necessary supplies. Because the injection procedure and manipulation procedure must be performed within 24 hours or each other, this activity is usually bundled into one phone call to schedule both procedures. We are recommending 3 minutes (a phone call) for this activity.

Provide pre-service education/obtain consent. There is typically at least several weeks lapse of time between patient decision to proceed with the injection and approval and scheduling of the procedure. After payer approval, clinical staff will call the patient to confirm the scheduled appointments and review the protocol and confirm the patient still wants to proceed with the injection and necessary follow-up. We are recommending 3 minutes (a phone call) for this activity.

Intra-Service Clinical Labor Activities:
No time is recommended for this service period.

Post-Service Clinical Labor Activities:
No time has been allotted for this service period.

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

CPT Long Descriptor:
Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord

Global Period: 010

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of surgeons familiar with the procedure compared the necessary practice expense details as they related to new code 205X1.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
This procedure will always follow within 24 hours of the injection procedure (205X1). Although clinical staff may receive a phone call regarding the swelling of the hand post injection and prior to coming to the office for this procedure, this is not typical. We are recommending no pre-service time.

Intra-Service Clinical Labor Activities:
Clinical staff will greet the patient and ensure appropriate medical records are available. The procedure supplies are assembled and procedure room prepared. Clinical staff will assist the surgeon during the injection of local anesthesia. Clinical staff will assist the surgeon 100% of the time for the manipulation procedure. Post-procedure, clinical staff will clean the room (while continuing to monitoring the patient) and review instructions until next visit.

Post-Service Clinical Labor Activities:
Time consistent with 99212 follow-up visit is indicated.

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

CPT Long Descriptor:
Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord

Global Period: 010

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
An expert panel of surgeons familiar with the procedure compared the necessary practice expense details as they related to new code 205X1.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:
This procedure will rarely be performed in a facility. When it is necessary, all pre-service clinical staff work will be bundled with injection preservice work. Therefore, we are not recommending pre-service clinical staff time for this code.

Intra-Service Clinical Labor Activities:
No time has been allotted for this service period.

Post-Service Clinical Labor Activities:
Time consistent with 99212 follow-up visit is indicated.

	A	B	C	D	E	F	G
1	AMA Specialty Society RVS Update Committee Recommendation						
2				**20527**		**26341**	
3	Meeting Date: April 2011			Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)		Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord	
4	**LOCATION**	**Code**	**Staff Type**	**OFF**	**FAC**	**OFF**	**FAC**
5	**GLOBAL PERIOD**			**0**	**0**	**10**	**10**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**28**	**11**	**50**	**27**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**8**	**11**	**0**	**0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**20**	**0**	**23**	**0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	RN/LPN/MTA	**0**	**0**	**27**	**27**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms	**L037D**	RN/LPN/MTA	**5**	**5**	**0**	**0**
13	Coordinate pre-surgery services	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**
14	Schedule space and equipment in facility	**L037D**	RN/LPN/MTA	**0**	**3**	**0**	**0**
15	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA	**3**	**3**	**0**	**0**
16	Follow-up phone calls & prescriptions	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**
18	**End:When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters site for procedure: Services Prior to Procedure**						
21	review charts	**L037D**	RN/LPN/MTA				
22	Greet patient, provide gowning, ensure appropriate medical records are available	**L037D**	RN/LPN/MTA	**3**		**3**	
24	Provide pre-service education/obtain consent	**L037D**	RN/LPN/MTA				
25	Prepare room, equipment, supplies	**L037D**	RN/LPN/MTA	**2**		**2**	
26	Prepare and position patient/ monitor patient/ set up IV	**L037D**	RN/LPN/MTA				
27	Sedate/apply anesthesia	**L037D**	RN/LPN/MTA			**2**	
28	**Intra-service**						
29	Assist physician in performing procedure - **100%**	**L037D**	RN/LPN/MTA	**5**		**10**	
30	**Post-Service**						
31	Monitor pt. following service/check tubes, monitors, drains	**L037D**	RN/LPN/MTA	**4**		**0**	
32	Clean room/equipment by physician staff	**L037D**	RN/LPN/MTA	**3**		**3**	
33	Check dressings & wound/ home care instructions /coordinate OV /prescriptions	**L037D**	RN/LPN/MTA	**3**		**3**	
35	**End: Patient leaves office**						
36	**POST-SERVICE Period**						
37	**Start: Patient leaves office/facility**						
38	Conduct phone calls/call in prescriptions			**0**	**0**	**0**	**0**
39	*Office visits:*						
42	99212 27 minutes		27			**1**	**1**
46	Other						
47	***Total Office Visit Time***	**L037D**	**RN/LPN/MTA**	**0**	**0**	**27**	**27**
49	**End: with last office visit before end of global period**						
50	**MEDICAL SUPPLIES**	**Code**	**Unit**				
51	gloves, sterile	**SB024**	**pair**	**1**		**1**	
52	drape, sterile barrier 16in x 29in	**SB007**	**item**	**1**		**1**	
53	povidone soln (Betadine)	**SJ041**	**ml**	**10**		**20**	
54	syringe 1ml	**SC052**	**item**	**2**			
55	needle, 18-27g	**SC029**	**item**	**2**		**2**	
56	syringe 10-12ml	**SC051**	**item**			**1**	
57	lidocaine 1%-2% inj (Xylocaine)	**SH047**	**ml**			**10**	
58	gauze, sterile 4in x 4in (10 pack uou)	**SG056**	**item**	**1**		**1**	
59	bandage, strip 0.75in x 3in (Bandaid)	**SG021**	**item**				
60	bandage, Kling, non-sterile 3in	**SG018**	**item**	**1**		**1**	
61	tape, surgical paper 1in (Micropore)	**SG079**	**inch**	**6**		**6**	
62	**Equipment**	**Code**					
63	table, power	**EF031**		**20**	**0**	**50**	**27**
64	light, surgical	**EF014**		**20**	**0**	**50**	**27**

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Fourth Five-Year Review - Harvard Valued – Utilization Over 30,000

April 2011

Contact Lens Fitting

In the 4th Five-Year Review of the RBRVS, CMS identified code 92070 *Fitting of contact lens for treatment of disease, including supply of lens* (work RVU = 0.70) through the Harvard-Valued – Utilization over 30,000 screen. Upon review of this service, the specialty societies agreed that there are two distinct uses for 92070 that have substantially different levels of work. In February 2011, the CPT Editorial Panel agreed and deleted code 92070 and created two new codes to distinguish reporting of fitting of contact lens for treatment of ocular surface disease and fitting of contact lens for management of keratoconus.

92071 ***Fitting of contact lens for treatment of ocular surface disease***
The RUC reviewed the survey results from 66 ophthalmologists and optometrists who perform this procedure. Eighty-five percent of the survey respondents believed the vignette was typical and the code would typically be used on the same day as an Evaluation and Management visit. This service involves identifying and fitting of the correct therapeutic contact lens for the corneal damaged eye, to facilitate healing. Although the survey respondents indicated the typical physician intra-service work time requires 15 minutes, the specialty society and the RUC agreed that only five minutes was typical in comparison to similar services, with a total time of 15 minutes. The survey respondents chose 65205 *Removal of foreign body, external eye; conjunctival superficial* (000 day global, work RVU = 0.71) as its key reference service and the RUC agreed that this reference code, with identical physician time components, should be valued similarly to 92071. The RUC compared the work of this service to that of code 65778 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* (010 day global, work RVU = 1.19) without its follow up visit. Although the survey indicated a median work RVU of 1.11, the specialty recommended, and the RUC agreed, that the original work value of 0.70 for CPT code 92070 was more appropriate. **The RUC recommends a work RVU of 0.70 for CPT code 92071.**

92072 ***Fitting of contact lens for management of keratoconus***
The RUC accepted compelling evidence that this service is separate from the original 92070 service and has never been valued in the past. In addition, the original code 92070 and new code 92071 were valued unilaterally whereas 92072 appropriately has been surveyed as being typically performed bilaterally. In addition, keratoconus is not seen in the Medicare population and it is not covered.

The RUC reviewed the survey results from 61 ophthalmologists and optometrists who perform this procedure. The specialty recommended 10 minutes of pre-service time to account for the review of all referring data on the patient and an extensive educational discussion concerning lens trials with the patient. A reduced immediate post service time from the survey was also recommended by the specialty to be only 10 minutes rather than 20 minutes. The specialty indicated and the RUC agreed that the immediate post service time, 10 minutes, appropriately mirrors the post service time of 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program;*

comprehensive, new patient, 1 or more visits (work RVU = 1.82). The RUC determined that the surveyed code is more complex, requires more time, 65 total minutes compared to 40 minutes, and is more intense than the work associated with 92004. The intensity and complexity of 92072 requires the physician to manage a warped cornea to get the correct specialty designed contact lens fit in each eye. Each eye is pathologically unique and requires evaluating the correct fit with dye and light. Therefore, the RUC determined that the median work RVU of 1.97 appropriately accounts for the work required to perform this service. **The RUC recommends a work RVU of 1.97 for CPT code 92072**

Referral to CPT:
The RUC referred CPT code 92072 to the CPT Editorial Panel to add language to the code to clarify that the service is the initial service for treatment of keratoconus and that subsequent contact lens fittings would be coded with a general ophthalmological exam or Evaluation and Management service.

Practice Expense:
The RUC reviewed and refined the direct practice expense inputs for 92071 and 92072 to reflect the typical patient service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Eye and Ocular Adnexa** **Anterior Segment** **Cornea** **Other Procedures**				
E 65775		Corneal wedge resection for correction of surgically induced astigmatism (For fitting of contact lens for treatment of disease, ~~use 92070~~ see, 92071, 92072) (For unlisted procedures on cornea, use 66999)	090	6.91 (No Change)
Medicine **Ophthalmology** **Special Ophthalmological Services**				

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 92070		~~Fitting of contact lens for treatment of disease, including supply of lens~~ (92070 has been deleted. To report, see 92071, 92072)	XXX	N/A
●92071	BB1	Fitting of contact lens for treatment of ocular surface disease (Do not report 92071 in conjunction with 92072) (Report supply of lens separately with 99070 or appropriate supply code)	XXX	0.70
●92072	BB2	Fitting of contact lens for management of keratoconus; initial fitting (For subsequent fittings, see E/M, 92012, 92014)) (Do not report 92072 in conjunction with 92071) (Report supply of lens separately with 99070 or appropriate supply code)	XXX	1.97

Contact Lens Services

The prescription of contact lens includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is NOT a part of the general ophthalmological services. The fitting of contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.

Follow-up of successfully fitted extended wear lenses is reported as part of a general ophthalmological service (92012 et seq).

The supply of contact lenses may be reported as part of the service of fitting. It may also be reported separately by using the appropriate supply codes.

(For therapeutic or surgical use of contact lens, see 68340, ~~92070~~ 92071, 92072)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92071 Tracking Number BB1 Original Specialty Recommended RVU: **0.70**
Presented Recommended RVU: **0.70**
Global Period: XXX RUC Recommended RVU: **0.70**

CPT Descriptor: Fitting of contact lens for treatment of ocular surface disease

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32 year-old male with eye pain, photophobia, and reduced vision after his eye was struck with a tree branch. He was found to have a corneal abrasion which requires a therapeutic contact lens to protect the corneal surface, reduce discomfort, and facilitate healing.

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

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: The process involved in placing the therapeutic contact lens is reviewed with the patient along with the risks and benefits of the treatment .

Description of Intra-Service Work: Topical anesthesia is administered. A therapeutic soft contact lens of the appropriate size and base curve is selected and applied to the cornea. A drop of topical antibiotic is administered. Fifteen minutes later the fit and centration of the lens is evaluated at the slit lamp.

Description of Post-Service Work: A prescription for topical antibiotics and appropriate instructions are given and any necessary follow up is explained.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Stephen Kamenetzky, M.D. and Michael Chaglasian, O.D.					
Specialty(s):	Ophthalmology and Optometry					
CPT Code:	92071					
Sample Size:	450	**Resp N:**	66	**Response:** 14.6 %		
Sample Type:	Random	**Additional Sample Information:** A random sample from comprehensive members and those who specialize in cornea disorders				
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	6.00	**12.00**	30.00	800.00
Survey RVW:		0.20	0.76	**1.11**	1.47	2.20
Pre-Service Evaluation Time:				**5.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		10.00	15.00	**15.00**	20.00	55.00
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** 99217x **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**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	92071	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
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:		**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** 99217x **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**		
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
65205	000	0.71	**RUC Time**

CPT Descriptor Removal of foreign body, external eye; conjunctival superficial

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
65778	010	1.19	**RUC Time**

CPT Descriptor Placement of amniotic membrane on the ocular surface for wound healing; self-retaining

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:** 21.2 **%**

TIME ESTIMATES (Median)	**CPT Code: 92071**	**Key Reference CPT Code:** 65205	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	5.00	
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 Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**15.00**	**15.00**	
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	3.08	2.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.69	2.54
Urgency of medical decision making	3.54	3.46
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.15	3.62
Physical effort required	2.69	2.92
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.38	3.38
Outcome depends on the skill and judgment of physician	3.46	3.62
Estimated risk of malpractice suit with poor outcome	3.46	3.31

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	2.31	2.38
Intra-Service intensity/complexity	3.31	3.54
Post-Service intensity/complexity	2.69	2.69

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.*

CPT 92070 *Fitting of contact lens for treatment of disease, including supply of lens* was selected for the fourth Five Year Review because it had a utilization of >30,000 and was Harvard valued. The AAO and the AOA requested that the code be referred to CPT in order to separate the two distinct

types of service defined by the code that have significantly different physician work and practice expense. Because the cost of a lens can vary widely, the societies also recommended that the supply of the lens be removed from the descriptor and a separate HCPCS code be used to report that cost. The RUC agreed and two new CPT codes were created. This code deals with the fitting of a bandage soft contact lens for the treatment of corneal disease.

The AAO and AOA each surveyed members and the results were combined. There were 66 responses with a response rate of 14.6%. Eighty-five percent thought that the vignette was typical. The median RVU was 1.14 and the 25th percentile 0.76. Median intra-service times were 5/15/8.5 minutes. The primary reference code chosen was CPT 65205 *removal of foreign body, external eye; conjunctival superficial* which has a WRVU of 0.71 and times of 5/5/5 minutes. The code would typically be used on the same day as an EM visit.

An expert panel familiar with the service and the RUC process reviewed the survey responses. It was felt that the times chosen by the respondents were too long and that times of 5/5/5 minutes would be more appropriate and these are the times that we are submitting for review.
In addition to the reference code chosen, CPT 65778 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* was felt to be a good comparison code. The code was reviewed by the RUC in Feb 2010 and a value of 1.19 was established with a 10day global period that included a 99212 visit to remove the carrier ring. Subtracting the 99212 work value of 0.48 results in a WRVU of 0.71. The times for 65778 are also 5/5/5 min and the services of placing a protective device on the eye to treat corneal surface disease are virtually identical. CPT 67820 *Correction of trichiasis; epilation, by forceps only (000)* has combined pre-and post-service times of 10 min, 5 min IST and a WRVU of 0.71. There are also a series of injection codes which have been RUC reviewed (CPT 64455, 20550, 20612 [000 global]) and have similar times with WRVU ranging from 0.71 to 0.75.

The AAO and AOA recommend the existing WRVU of 0.70 which is below the 25th percentile on the survey.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) This service is done in conjuntion with an office 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. The MD or OD would bill one of the following visit codes at which time this scan would also be perfomed.

3.	CPT Code	Pre	Intra	Post-	Total Time	Work RVU	Global Period
4.	92002	5	15	5	25	.88	XXX
5.	92004	5	25	10	40	1.82	XXX
6.	92012	5	15	5	25	.92	XXX

7.	92014	5	24	8	37	1.42	XXX
8.	99213	3	15	5	23	.97	XXX

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92070

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 Optometry How often? Commonly

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?
44,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Ophthalmology Frequency 30000 Percentage 68.18 %

Specialty Optometry Frequency 13500 Percentage 30.68 %

Specialty Frequency 0 Percentage 0.00 %

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

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92070

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92072 Tracking Number BB2 Original Specialty Recommended RVU: **1.97**
Presented Recommended RVU: **1.97**
Global Period: XXX RUC Recommended RVU: **1.97**

CPT Descriptor: Fitting of contact lens for management of keratoconus

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27 year-old female with keratoconus is unable to read or drive safely with glasses or conventional contact lenses. Her best corrected visual acuity is 20/60 OD, and 20/200 OS due to irregular astigmatism from keratoconus. A custom contact lens fit and design is medically necessary for visual rehabilitation.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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: The contact lens fitting process is reviewed with the patient along with the risks and benefits as well as long-term prognosis. Different lens fitting options are discussed along with the expectations for improved visual acuity.

Description of Intra-Service Work: Results of diagnostic tests done prior to contact lens fitting to assess the corneal ectasia are used in concert with slit lamp examination to assess corneal shape and determine initial contact lens parameters (e.g. diameter, base curve and secondary curves). Lens designs can include corneal, scleral, hybrid or piggyback systems. Keratometry, lid anatomy, tear film and refraction are also performed/rechecked.

An initial diagnostic lens is selected for each eye and placed on the eyes. The patient is examined after adequate time for the lens to settle in order to evaluate the lens fit. Fluorescein dye is instilled in the eye to evaluate the posterior tear pattern, lens position and corneal relationship. Based on the fit of the first diagnostic lens, the lens parameters are recalculated. This includes base curves, secondary curves and lens design. This process is repeated until the lens is well-centered and comfortable. A typical fitting requires three different diagnostic lenses per eye. An over-refraction is performed to determine final contact lens power.

Description of Post-Service Work: A suitable contact lens polymer is selected and final lens design parameters are calculated and prescribed. A technician discusses the appropriate discussions regarding lens handling and care, lens wear and potential complications are provided to the patient. Follow-up is arranged.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	Stephen Kamenetzky, M.D. and Michael Chaglasian, O.D.		
Specialty(s):	Ophthalmology and Optometry		
CPT Code:	92072		
Sample Size:	450	**Resp N:** 61	**Response:** 13.5 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**30.00**	84.00	175.00
Survey RVW:	0.90	1.80	**1.97**	2.29	6.65
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	90.00

Immediate Post Service-Time:	**20.00**	
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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	92072	**Recommended Physician Work RVU: 1.97**		
		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:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**10.00**	
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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
92004	XXX	1.82	**RUC Time**

CPT Descriptor Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
29445	000	1.78	**RUC Time**	13,152

CPT Descriptor 1 Application of rigid total contact leg cast

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99233	XXX	2.00	**RUC Time**	20,842,871

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity.

Other Reference CPT Code	Global	Work RVU	Time Source
90937	000	2.11	**RUC Time**

CPT Descriptor Hemodialysis

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: 48 **% of respondents:** 78.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 92072**	**Key Reference CPT Code:** 92004	**Source of Time RUC Time**
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	45.00	25.00	
Median Immediate Post-service Time	10.00	10.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**65.00**	**40.00**
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	4.04	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	3.69
Urgency of medical decision making	3.33	3.23
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.85	3.77
Physical effort required	3.85	3.19
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.75	3.27
Outcome depends on the skill and judgment of physician	4.81	3.79
Estimated risk of malpractice suit with poor outcome	3.40	3.31

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.67	3.04
Intra-Service intensity/complexity	4.70	3.64
Post-Service intensity/complexity	4.06	3.08

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.*

CPT 92070 *Fitting of contact lens for treatment of disease, including supply of lens* was selected for the fourth Five Year Review because it had a utilization of >30,000 and was Harvard valued. The AAO and the

AOA requested that the code be referred to CPT in order to separate the two distinct types of service defined by the code that have significantly different physician work and practice expense. Because the cost of a lens can vary widely, the societies also recommended that the supply of the lens be removed from the descriptor and a separate HCPCS code be used to report that cost. The RUC agreed and two new CPT codes were created by the Editorial Panel. This new code deals with the fitting of rigid contact lenses for the treatment of keratoconus, a condition that causes the normal dome-shaped cornea to progressively thin and form a cone-shaped bulge. This service is not typically performed in the Medicare population. The existing code would represent the service that will be coded by 9207X1 (being reviewed separately) which is a covered service. CPT code 9207X2 will represent a service not readily coded previously.

Compelling evidence to support our recommended work value: The work of fitting a contact lens for keratoconus is substantially more involved and utilizes many additional techniques than would be typical for 92070 or 9207X1. The keratoconus service was previously billed using the existing code which met the descriptor of the service, but not the work, techniques and lenses utilized which are substantially different and better represented with the new code 920X2.

The AAO and AOA each surveyed members and the results were combined. There were 61 responses with a response rate of 13.5%. Ninety-seven percent thought that the vignette was typical. The median RVU was 1.97 and the 25th percentile 1.80. Median intra-service times were 15/45/20 minutes. The primary reference code chosen was CPT 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* which has a WRVU of 1.82 and times of 5/25/10 minutes. The reference code chosen has an intra-service time which is 20 minutes less than 9207X2. The survey respondents felt that the intensities and complexities were similar in most areas. The one difference was that the successful outcome was dependent on the skill of the practitioner where the surveyed code was much higher than the reference code. The code would typically NOT be used on the same day as an E/M visit. The work value estimate was for fitting of both eyes which would be typical as keratoconus is a bilateral disease.

An expert panel familiar with the service and the RUC process reviewed the survey responses. Fitting of lenses in patients with keratoconus is a time-consuming process involving the assessment of the fit of a series of trial contact lenses of known material, diameter and base curve. About 3 lenses are tried per eye to achieve the desired size and base curve that produces a stable fit. Each evaluation takes about 6 minutes/eye to assess the fit at slit lamp and calculate the changes needed improve vision and comfort. Usually the two eyes behave entirely independently due to the asymmetric nature of the pathology. After the proper lens is selected, an over-refraction of that lens is done to determine the proper power. This process takes about 45 minutes (18 min/eye x 2+refraction of each eye) which is the survey IST. The panel felt that the survey pre- and post-times were too long and therefore we are recommending times of 10/45/10.

There are several 000 global RUC reviewed codes with times similar to the code being surveyed. CPT 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* has a WRVU of 2.11 with time of 10/40/10. CPT 11921 *Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm* has the same IST, longer pre- and post-times and a WRVU of 1.93. CPT 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* has similar pre- and post- times and only 30 minutes of IST and has a WRVU of 2.00. The surveyed code is less intense and complex than 99233, but has an IST that is 50 % longer.

The specialties recommend the median WRVU of 1.97.

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) 92070

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? Sometimes

Specialty Optometry How often? Sometimes

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? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Not performed in the Medicare population

Specialty	Frequency	Percentage	%
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)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92070

	A	B	C	D	E	F	G
1	**AMA Specialty Society RVS Update Committee Recommendation**			**92071**		**92072**	
2	**Meeting Date:April 2011**	**CMS**	**Staff**	**Fitting of Contact Lens for Rx of ocular surface disease**		**Fitting of Contact Lens for management of Keratoconus**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**			**xxx**	**xxx**	**xxx**	**xxx**
5	**TOTAL CLINICAL LABOR TIME**			**5.0**	**0.0**	**48.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**5.0**	**0.0**	**42.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**6.0**	**0.0**
9	**PRE-SERVICE**						
10	**Start: Following visit when decision for surgery or procedure made**						
11	Complete pre-service diagnostic & referral forms						
12	Coordinate pre-surgery services						
13	Schedule space and equipment in facility						
14	Provide pre-service education/obtain consent						
15	Follow-up phone calls & prescriptions						
16	Other Clinical Activity (please specify)						
17	**End: When patient enters office/facility for surgery/procedure**						
18	**SERVICE PERIOD**						
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**						
20	Greet patient, provide gowning, ensure appropriate medical records are available						
21	Obtain vital signs						
22	Provide pre-service education/obtain consent		L038A			2	
23	Prepare room, equipment, supplies		L038A			2	
24	Setup scope (non facility setting only)						
25	Prepare and position patient/ monitor patient/ set up IV						
26	Sedate/apply anesthesia						
27	**Intra-service**						
28	Assist physician in performing procedure		L038A	**5**		15	
29	**Post-Service**						
30	Monitor pt. following service/check tubes, monitors, drains						
31	Clean room/equipment by physician staff		L038A			3	
32	Clean Scope						
33	Clean Surgical Instrument Package						
34	Complete diagnostic forms, lab & X-ray requisitions						
35	Review/read X-ray, lab, and pathology reports						
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions						
37	Discharge day management						
38	Teach insert/remove, care		L038A			20	
39	**End: Patient leaves office**						
40	**POST-SERVICE Period**						
41	**Start: Patient leaves office/facility**						
42	Conduct phone calls/call in prescriptions		L038A			6	
43	*Office visits:*						
44	*List Number and Level of Office Visits*						
45	99211 16 minutes		16				
46	99212 27 minutes		27				
47	99213 36 minutes		36				
48	99214 53 minutes		53				
49	99215 63 minutes		63				
50	99238 12 minutes		12				
51	*Total Office Visit Time*			**0**	**0**	**0**	**0**
52	Other Activity (please specify)						
53	**End: with last office visit before end of global period**				**0**		0
54	**MEDICAL SUPPLIES**		**Unit**				
55	Ophthalmology visit package	SA050				1	
56							
57							
58							
59	**Equipment**						
60	screening lane	EL006		**15**		42	
61	keratoconus contact lens fitting set					42	
62							

Typical Patient (9207X1)

A 32 year-old male with eye pain, photophobia, and reduced vision after his eye was struck with a tree branch. He was found to have a corneal abrasion which requires a therapeutic contact lens to protect the corneal surface, reduce discomfort, and facilitate healing.

Typical Patient (9207X2)

A 27 year-old female with keratoconus is unable to read or drive safely with glasses or conventional contact lenses. Her best corrected visual acuity is 20/60 OD, and 20/200 OS due to irregular astigmatism from keratoconus. A custom contact lens is designed and fit.

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Originated from the Relativity Assessment Workgroup –
Different Specialty Performing from Survey, Codes Reported Together 75% or More, and High Volume Growth Screens

February 2011

Electronic Analysis Implanted Pump

The Relativity Assessment Workgroup identified codes 62367, 62368, 95990 and 95991 as part of the Codes Reported Together 75% or More screen. In April 2010, the RUC recommended to refer these services to the CPT Editorial Panel to revise and describe those services with three separate codes. In October 2010, the CPT Editorial Panel created two new codes, 62369 and 62370, to report electronic analysis of programmable implanted pump for intrathecal or epidural drug infusion with reprogramming, with reprogramming and refill requiring and not requiring physician's skill and editorially revised three existing codes, 62367 to report without reprogramming or refill and codes 95990 and 95991, to report refilling and maintenance of implantable pump or reservoir for drug delivery requiring and not requiring physician skill.

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 or refill***
The RUC reviewed the survey results of 34 pain medicine physicians, anesthesiologists and spine physicians for CPT code 62367 and agreed with the specialty societies that the current work RVU of 0.48 appropriately accounts for the physician work required to perform this service. Additionally, the RUC agreed with the specialty society that the pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes appropriately accounts for the work required to perform this service. The CPT Editorial Panel editorially revised this service to add "without refill" and the specialty societies indicated and the RUC agreed that this does not change the physician work required to perform this procedure. To further support the current work RVU of 0.48, the RUC compared 62367 to MPC codes 95900 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study* (work RVU = 0.42) and 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU = 0.50) and determined that the current value maintains the appropriate relativity among these similar services. **The RUC recommends maintaining the current work RVU of 0.48 for CPT code 62367.**

62369 ***Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill***
The RUC reviewed the survey results for CPT code 62369 and recommends that the survey 25th percentile work RVU of 0.67, as it appropriately accounts for the physician work required to perform this service. The RUC recommends pre-service time of 7 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. The RUC determined that the pre-service is slightly higher for 62369 compared to 62367 to account for the physician ordering the solution to be injected into the pump/reservoir.

The RUC reviewed two reference services to support the 25th percentile work RVU of 0.67. CPT code 93294 *Interrogation device evaluation(s), up to 90 days (*work RVU= 0.65 and pre-time= 7.5 minutes, intra-time= 15 minutes and post time= 7.5 minutes) and code 99241 *Office consultation for a new or established patient* (work RVU= 0.64 and pre-time= 5 minutes, intra-time= 15 minutes and post time= 5 minutes) were reviewed and the RUC agreed that these services, with similar physician time, ensures the recommended value is relative across physician services. **The RUC recommends a work RVU of 0.67 for CPT code 62369.**

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***
Although CPT code 62368 was not surveyed, the RUC indicated and the specialty society agreed, that CPT code 62368 requires the exact same physician work and time as 62369, as the work involved in refilling the pump is done solely by clinical staff. Given that the physician work is identical between the two services, the RUC noted that the current work RVU of 0.75 for 62368 would created a rank order anomaly compared to 62369. Therefore, the RUC recommends to directly crosswalk the physician work RVUs, 0.67, and physician time of 7 minutes pre-time, 15 minutes intra-time and 5 minutes immediate post-time. **The RUC recommends a work RVU of 0.67 for CPT code 62368.**

62370 ***Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)***
The RUC reviewed the survey results for CPT code 62370 and recommends crosswalking the physician work to 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU = 1.10 and total time = 35 minutes) as the 0.43 work difference compared to 62369 appropriately accounts for the physician skill required for this procedure (1.10-0.67=0.43). To further justify this value, the RUC referenced many services that have a work RVU of 1.10 and similar physician time that ensures the recommended value is relative across all physician services. These code references include CPT codes, 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (work RVU = 1.10 and total time = 35 minutes) and 99379 *Physician supervision of a nursing facility patient* (work RVU = 1.10 and total time = 35 minutes). The RUC recommends pre-service time of 7 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. **The RUC recommends a work RVU of 1.10 for CPT code 62370.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense:
The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was refined with a comparison to the direct practice expenses of existing chemotherapy services.

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲62367	G1	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill	XXX	0.48 (No Change)
62368	G4	with reprogramming (For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, see 95990-95991)	XXX	0.67
●62369	G2	with reprogramming and refill	XXX	0.67
●62370	G3	with reprogramming and refill (requiring physician's skill) (Do not report 62367-62370 in conjunction with 95990, 95991. For refilling and maintenance of a reservoir or an implantable infusion pump for spinal or brain drug delivery without reprogramming, see 95990, 95991)	XXX	1.10
E 95990		Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed ~~(For analysis and/or reprogramming of implantable infusion pump, see 62367-62368~~ ~~(For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy [eg, chemotherapy or insulin], use 96522)~~	XXX	0.00 (No Change)
E 95991		~~administered by physician~~ requiring physician's skill Do not report 95990-95991 in conjunction with 62367-62370. For analysis and/or reprogramming of implantable infusion pump, see 62367-62370)	XXX	0.77 (No Change)

CPT Code (●New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy [eg, chemotherapy], use 96522)		

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:62367 Tracking Number G1 Original Specialty Recommended RVU: **0.48**
Presented Recommended RVU: **0.48**
Global Period: XXX RUC Recommended RVU: **0.48**

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

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male presents for an electronic analysis of an implanted infusion pump that delivers opiates and has successfully controlled his pain due to prostate cancer and metastases to multiple bone sites in the lower body and resultant bilateral leg and pelvic bone pain (rated 8/10). Because of the multiple sites of bone involvement and lack of response to chemotherapy, no radiation therapy or further chemotherapy is planned. His expected survival time is 9 months from his cancer. The electronic analysis of the implanted pump device, which determines the rate of infusion and the amount of morphine solution remaining in the pump reservoir, indicates a satisfactory infusion rate and residual volume; so no reprogramming or refill is needed.

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? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 3%

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? 3%

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-serivice includes: a review of patient medical chart with special attention to patient's response to drug delivery via implanted infusion pump

Description of Intra-Service Work: Electronic analysis is performed to determine reservoir status, alarm status, and the drug prescription status. Because the electronic analysis of the implanted pump device indicates a satisfactory infusion rate and residual volume; no reprogramming or refill is needed.

Description of Post-Service Work: Communication with the patient, family, and other health care professionals (including written and telephone reports and orders) on the day of the analysis are considered part of the post-operative work for this procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011		
Presenter(s):	Eduardo Fraifeld, MD, Fred Davis, MD, Joseph Zuhosky, MD, Marc Leib, MD, Christopher Merifield, MD, Bill Sullivan, MD, Charlie Mick, MD, David Carroway, MD, Chris DeWald, MD		
Specialty(s):	AAPM,AAPMR,ASA,ISIS,NASS,ASIPP		
CPT Code:	62367		
Sample Size:	720	**Resp N:** 34	**Response:** 4.7 %
Sample Type:	Panel **Additional Sample Information:** Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.50	**13.50**	47.50	500.00
Survey RVW:	0.08	0.54	**0.91**	1.44	2.20
Pre-Service Evaluation Time:			**6.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**10.00**	15.00	25.00

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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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); 99224 (20); 99225 (40); 99226 (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:	62367	**Recommended Physician Work RVU: 0.48**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
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:		**10.00**		

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** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	0.97	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95900	XXX	0.42	**RUC Time**	1,371,085

CPT Descriptor 1 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
92083	XXX	0.50	**RUC Time**	2,580,775

CPT Descriptor 2 Visual field examination, unilateral or bilateral,with interpretation and report; extended examination (eg Goldman visual fields with at least 3 isopters plotted and static determination within the central 30' or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2

Other Reference CPT Code	Global	Work RVU	Time Source
69210	000	0.61	**RUC Time**

CPT Descriptor Removal impacted cerumen (separate procedure) 1 or both ears

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:** 23.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 62367**	**Key Reference CPT Code:** 99213	**Source of Time** RUC Time
Median Pre-Service Time	5.00	3.00	
Median Intra-Service Time	10.00	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
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**20.00**	**23.00**
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	3.13	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.38
Urgency of medical decision making	3.13	3.13
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.38	2.28
Physical effort required	3.13	2.75
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.75	3.25
Outcome depends on the skill and judgment of physician	3.75	3.50
Estimated risk of malpractice suit with poor outcome	3.75	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	2.88
Intra-Service intensity/complexity	3.38	3.38
Post-Service intensity/complexity	2.75	2.63

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.*
Code 62367 is part of a family of codes revised to combine the refilling of implantable pumps with codes for analysis and reprogramming. Code 62367 describes an analysis without reprogramming. The code was changed to add "without refill" to the descriptor and does not represent a change in the work of the existing code. The specialty societies agreed that the work was unchanged and recommend the current wRVU of 0.48 be maintained. Although this is below the survey 25th percentile, the societies felt the current value accurately represented the wRVU.

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) 62367

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 Interventional Pain Management How often? Commonly

Specialty Physical Medicine and Rehab How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 30230
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The societies estimate that approximately 44% of the total procedures are performed on Medicare beneficiaries..

Specialty Anesthesiology Frequency 8767 Percentage 29.00 %

Specialty Interventional Pain Management Frequency 5441 Percentage 17.99 %

Specialty Physical Medicine and Rehab Frequency 4837 Percentage 16.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 13,146 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Per the RUC database the 2009 frequency was 13,146

Specialty Anesthesiology Frequency 3858 Percentage 28.99 %

Specialty Interventional Pain Frequency 2395 Percentage 18.00 %

Specialty Physical Medicine & Rehab Frequency 2129 Percentage 16.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 62367

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:62369 Tracking Number G2 Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.75**
Global Period: XXX RUC Recommended RVU: **0.67**

CPT Descriptor: Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65- year- old male has prostate cancer and metastases to multiple bone sites in the lower body and resultant bilateral leg and pelvic bone pain. A permanent implantable subcutaneous programmable infusion pump and an intrathecal infusion catheter were implanted for a long- term intrathecal infusion of narcotic. Because of inadequate pain control the patient now presents for refill and reprogramming of his pump, not requiring physician's skill

Percentage of Survey Respondents who found Vignette to be Typical: 82%

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: Pre-service includes a review of patient medical chart with special attention to patient's response to drug delivery via implanted infusion pump. The solution to be injected into the pump/reservoir is ordered by the physician

Description of Intra-Service Work: The nurse fills the pump under physician supervision and then electronic analysis is performed to determine reservoir status, alarm status, and the drug prescription status. Electronic analysis of the pump function verifies the infusion rate. Based on the patient’s evaluation the pump is then reprogrammed to adjust the rate of infusion and control the increased level of pain. The pump alarm settings and reservoir levels are programmed as well as any changes made to the drug infusion concentration or mixture. Refill date estimates are also made.

Description of Post-Service Work: Communication with the patient, family, and other health care professionals (including written and telephone reports and orders) on the day of the analysis and reprogramming are considered part of the post-operative work for this procedure as well as a follow up phone call to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011		
Presenter(s):	Eduardo Fraifeld, MD, Fred Davis, MD, Joseph Zuhosky, MD, Marc Leib, MD, Christopher Merifield, MD, Bill Sullivan, MD, Charlie Mick, MD, David Carroway, MD, Chris DeWald, MD		
Specialty(s):	AAPM, ASA, AAPMR, ASIPP, ISIS, NASS		
CPT Code:	62369		
Sample Size:	723	**Resp N:** 28	**Response:** 3.8 %
Sample Type:	Panel **Additional Sample Information:** Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**10.00**	50.00	800.00
Survey RVW:	0.18	0.67	**0.79**	1.74	3.01
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	5.00	**15.00**	20.00	30.00

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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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); 99224 (20); 99225 (40); 99226 (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:	62369	**Recommended Physician Work RVU: 0.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
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**		

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** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
95991	XXX	0.77	**RUC Time**

CPT Descriptor REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR RESERVOIR FOR DRUG DELIVERY, SPINAL (INTRATHECAL, EPIDURAL) OR BRAIN (INTRAVENTRICULAR); ADMINISTERED BY PHYSICIA

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20600	000	0.66	**CMS Time File**	389,742

CPT Descriptor 1 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	2,352,028

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem-focused history, an expanded problem-focused examination; straightforward medical decision making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the presenting problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of low or moderate serverity.. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

Other Reference CPT Code	Global	Work RVU	Time Source
20610	000	0.79	**CMS Time File**

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

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:** 35.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 62369**	**Key Reference CPT Code:** 95991	**Source of Time** **RUC Time**
Median Pre-Service Time	7.00	10.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	5.00	7.00	
Median Critical Care Time	0.0	0.00	

Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**27.00**	**37.00**
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	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.20
Urgency of medical decision making	2.70	2.70
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.70	3.00
Physical effort required	2.30	2.60
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.40	3.40
Outcome depends on the skill and judgment of physician	3.00	3.30
Estimated risk of malpractice suit with poor outcome	3.70	3.60

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.70	2.80
Intra-Service intensity/complexity	2.80	3.10
Post-Service intensity/complexity	2.80	2.90

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.*

Code 62369 is part of a family of codes revised to combine the refilling of implantable pumps with codes for analysis and reprogramming. 62369 describes reprogramming and refilling of the implantable pump without the skills of a physician and was previously reported with codes 62368 (wRVU 0.75) and 95990 (w RVU 0.0). The specialties societies recommend that the work RVU is equal to code 62368 and recommend the work RVU of 0.75. This is slightly less than the survey median of 0.79.

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) 62368 and 95990

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 Interventional Pain Management How often? Commonly

Specialty Pain Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 130809
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The societies estimate that 44% of the total procedures are performed on Medicare beneficiaries.

Specialty Anesthesiology Frequency 28778 Percentage 22.00 %

Specialty Interventional Pain Frequency 36627 Percentage 28.00 %

Specialty Pain Medicine Frequency 13081 Percentage 10.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 47,902 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 12662 Percentage 21.99 %

Specialty Interventional Pain Frequency 16116 Percentage 28.00 %

Specialty Pain Medicine Frequency 5756 Percentage 10.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95991

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:62370 Tracking Number G3 Original Specialty Recommended RVU: **1.45**
Presented Recommended RVU: **1.45**
Global Period: XXX RUC Recommended RVU: **1.10**

CPT Descriptor: Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male has prostate cancer and metastases to multiple bone sites in the lower body and resultant bilateral leg and pelvic bone pain. A permanent implantable subcutaneous programmable infusion pump and an intrathecal infusion catheter were implanted for a long- term intrathecal infusion of narcotic. Because of inadequate pain control the patient now presents for refill (requiring physician's skill because of difficult access or other medical issues OR complex reprogramming of his pump)

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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 includes a review of patient medical chart with special attention to patient's response to drug delivery via implanted infusion pump. The solution to be injected into the pump/reservoir is ordered by the physician.

Description of Intra-Service Work: Electronic analysis is performed to determine reservoir status, alarm status, drug prescription status. The subcutaneous pump is palpated and identified. The entire area over the pump is prepped and draped. Throughout all this procedure, sterile technique is meticulous to prevent infection. A pump refill kit is then opened and extra required supplies added to the kit
The solution’s container is checked to be sure that the drug, the drug volume, and the drug’s concentration are all correct according to what was ordered. Using sterile technique, the drug to be injected into the pump is then drawn from its transport vial into a sterile syringe using a filter needle.
The syringe is then connected to a Huber needle with an extension tube in the kit. The needle is advanced and probed to find the actual center of the pump reservoir and advanced through the injection septum of the pump into the reservoir to the proper depth. The residual volume of the solution is aspirated from the pump/reservoir and is measured and checked against the medical records and/or pump status printout to make sure the entire volume of the pump/reservoir has been

removed. The syringe containing the new solution attached to the tubing and then very slowly injected into the pump/reservoir. The patient is examined and pump/reservoir are then checked for any possible error in administration. The pump is then reprogrammed to adjust the rate of infusion and control the increased level of pain. The pump alarm settings and reservoir levels are programmed as well as any changes made to the drug infusion concentration or mixture. Refill date estimates are also made.

Description of Post-Service Work: Communication with the patient, family, and other health care professionals (including written and telephone reports and orders) on the day of the analysis and reprogramming are considered part of the post-operative work for this procedure as well as a follow up phone call to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011		
Presenter(s):	Eduardo Fraifeld, MD, Fred Davis, MD, Joseph Zuhosky, MD, Marc Leib, MD, Christopher Merifield, MD, Bill Sullivan, MD, Charlie Mick, MD, David Carroway, MD, Chris DeWald, MD		
Specialty(s):	AAPM, ASA, AAPMR, ASIPP, ISIS, NASS		
CPT Code:	62370		
Sample Size:	723	**Resp N:** 29	**Response:** 4.0 %
Sample Type:	Panel **Additional Sample Information:** Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**15.00**	50.00	500.00
Survey RVW:	0.75	0.80	**1.45**	2.25	3.55
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	15.00	**20.00**	25.00	45.00

Immediate Post Service-Time:	**10.00**	
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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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); 99224 (20); 99225 (40); 99226 (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:	62370	**Recommended Physician Work RVU: 1.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
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:		**20.00**		

Immediate Post Service-Time:	**10.00**	
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** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**

Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
95991	XXX	0.77	**RUC Time**

CPT Descriptor REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR RESERVOIR FOR DRUG DELIVERY, SPINAL (INTRATHECAL, EPIDURAL) OR BRAIN (INTRAVENTRICULAR); ADMINISTERED BY PHYSICIAN

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.42	**RUC Time**	5,468,748

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an new patient, which requires thesen3 key components: a detailed history, a detailed examination; and decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the presenting problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.50	**RUC Time**	72,747,651

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2of these 3 key components: a detailed history, a detailed examination; and decision making of moderate complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the presenting problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family

Other Reference CPT Code	Global	Work RVU	Time Source
73219	XXX	1.62	**RUC Time**

CPT Descriptor Magnetic resonance (eg proton) imaging, upper extremity, other than joint; with contrast material(s)

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:** 34.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 62370**	**Key Reference CPT Code:** 95991	**Source of Time** **RUC Time**
Median Pre-Service Time	7.00	10.00	
Median Intra-Service Time	20.00	20.00	

Median Immediate Post-service Time	10.00	7.00
Median Critical Care Time	0.0	0.00
Median Other Hospital Visit Time	0.0	0.00
Median Discharge Day Management Time	0.0	0.00
Median Office Visit Time	0.0	0.00
Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	**37.00**	**37.00**
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	2.80
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	2.80
Urgency of medical decision making	2.70	2.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.10
Physical effort required	3.00	2.70
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.60	3.20
Outcome depends on the skill and judgment of physician	3.60	3.30
Estimated risk of malpractice suit with poor outcome	3.70	3.30

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	2.60
Intra-Service intensity/complexity	3.60	3.10
Post-Service intensity/complexity	2.50	2.10

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.*
Code 62370 is part of a family of codes revised to combine the refilling of implantable pumps with codes for analysis and reprogramming. 62370 describes reprogramming and refilling of the implantable pump requiring physician skill and was previously reported with codes 62368 (wRVU 0.75) and 95991 (w RVU 0.77). The combined work of these existing codes equals 1.52 wRVUs. The specialties societies believes the work is unchanged and recommend the survey median of 1.45 which is less than the combined work of codes 62368 and 95991.

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) 62368 and 95991

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 Interventional Pain How often? Commonly

Specialty Pain Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 185634
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The societies estimate that 44% of the total procedures are performed on Medicare beneficiaries

Specialty Anesthesiology Frequency 70541 Percentage 38.00 %

Specialty Interventional Pain Frequency 38983 Percentage 20.99 %

Specialty Pain Medicine Frequency 25989 Percentage 14.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 71,424 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 31038 Percentage 37.99 %

Specialty Interventional Pain Frequency 17153 Percentage 21.00 %

Specialty Pain Medicine Frequency 11435 Percentage 13.99 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 95991

	A	B	C	D	E	F	G	H	I	J	K
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**62367**		**62368**		**62369**		**62370**	
2	**Meeting Date: February 2011**	**CMS**		**Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming**		**Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming**		**Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)**		**Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**										
5	**TOTAL CLINICAL LABOR TIME**			**29.0**	**0.0**	**36.0**	**0.0**	**75.0**	**0.0**	**71.0**	**0.0**
6	**RN/LPN/MTA**	**L037D**									
7	**RN**	**L051A**									
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**6.0**	**0.0**	**6.0**	**0.0**	**12.0**	**0.0**	**12.0**	**0.0**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**20.0**	**0.0**	**27.0**	**0.0**	**66.0**	**0.0**	**56.0**	**0.0**
10	**RN/LPN/MTA**	**L037D**		**20.0**		**27.0**		**55.0**		**55.0**	
11	**RN**	**L051A**						**11.0**		**1.0**	
12	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**		**0.0**	**0.0**	**3.0**	**0.0**	**3.0**	**0.0**	**3.0**	**0.0**
13	**PRE-SERVICE**										
14	**Start: Following visit when decision for surgery or procedure made**										
15	Complete pre-service diagnostic & referral forms	L037D		3		3		3		3	
16	Coordinate pre-surgery services	L037D		3		3		3		3	
17	Schedule space and equipment in facility										
18	Provide pre-service education/obtain consent										
19	Follow-up phone calls & prescriptions	L037D						3		3	
20	Other Clinical Activity (verify Rx X2,charting, review previous printout, proper storage (locked area) Schedule II drugs)	L037D						3		3	
21	**End: When patient enters office/facility for surgery/procedure**										
22	**SERVICE PERIOD**										
23	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**										
24	Interval history obtained by pain medicine nurse regarding course of treatment and pain related medical history	L037D		3		3		3		3	
25	Greet patient, provide gowning, ensure appropriate medical records are available	L037D		3		3		3		3	
26	Obtain vital signs	L037D		3		3		3		3	
27	Provide pre-service education/obtain consent	L037D						3		3	
28	Prepare room, equipment, supplies	L037D		2		2		2		2	
29	Setup scope (non facility setting only)										
30	Prepare and position patient	L037D						1		1	
31	Verify medication interaction, verify orders, second verification orders	L051A						0		0	
32	Assemble supplies	L037D						0		0	
33	**Intra-service**										
34	Assist physician in performing procedure										
35	RN/LPN/MTA	L037D		5		10		20		20	
36	RN	L051A						10			
37	**Post-Service**										
38	Monitor pt. following service	L037D						8		8	
39	Clean room/equipment by physician staff	L037D		3		3		3		3	

	A	B	C	D	E	F	G	H	I	J	K
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**62367**		**62368**		**62369**		**62370**	
2	**Meeting Date: February 2011**	**CMS**		**Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming**		**Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming**		**Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)**		**Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)**	
3	**LOCATION**	**Code**	**Type**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**	**Non Facility**	**Facility**
40	Complete **medical record documentation**, diagnostic forms, lab & X-ray requisitions, schedule II wasting	L037D		1		1		3		3	
41	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions	L037D				2		4		4	
42	**End: Patient leaves office**										
43	**POST-SERVICE Period**										
44	**Start: Patient leaves office/facility**										
45	Conduct phone calls/call in prescriptions	L037D				3		3		3	
46	**End: with last office visit before end of global period**										
47	**MEDICAL SUPPLIES**		**Unit**								
48	Minimun Supply Package for Vistis (Multi-specialty)			1		1		1		1	
49	Kit, refill for implantable medication pump	SA076						1		1	
50	Gloves, sterile	SB024						1		1	
51	Mask, surgical	SB033						1		1	
52	Syringe 20ml	SC053						2		2	
53	Povidone swabsticks (3 pack uou)	SJ043						1		1	
54	Bandage, strip 0.75in x 3in (Bandaid)	SG021						1		1	
55	Gauze, sterile 4in x 4in	SG055						1		1	
56	Needle, 18-27g	SC029						2		2	
57	Underpad 2ft x 3ft (Chux)	SB044						1		1	
58	**EQUIPMENT**										
59	Programmer, for implanted medication pump (spine), w-printer	EQ208		10		15		25		25	
60	Exam, power	EF031		10		15		25		25	
61											

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

CPT Long Descriptor:

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 or refill

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

62369 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)

62370 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)

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:

Representatives from each of the associated Specialty Societies, including physicians who provide these services, met via conference call to discuss specific PE inputs. Existing inputs for existing codes 62367, 62368 , 95990 and 95991 were reviewed as well as proposed changes developed for the October 2010 RUC meeting.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review records and complete forms required for patient's chart
- For codes that include refill of pump, the nurse must handle the order for the patient specific and custom formulated narcotic mixture. The pharmacy must be contacted directly since there may be multiple Schedule II narcotics involved. A hard copy of the prescription must be sent to the pharmacy and follow-up fax and phone call of the prescription is required. Once the medication is received, the nursing personnel must confirm the correct formulation by comparing it to the prescription and previous printouts, record receiving the medication and assure safe storage (locked container) until the procedure. Since Schedule II narcotics are involved, two clinicians must verify and document that the received medication agrees with the original prescription and ensure secure and proper storage. When the medication has arrived the patient is contacted, instructions are reviewed and the pump refill is scheduled.

Intra-Service Clinical Labor Activities:

- Greet patient and obtain vital signs
- Advise patient on appropriate cautions and concerns and obtain consent
- Prepare room and equipment including warming of machine
- Obtain printout and compare to previous settings
- Assist with placement and operation of pump programmer to determine pump parameters such as reservoir status, alarm status, and drug prescription activities
- If reprogramming required, assist with reprogramming and evaluation and recording of new pump parameters
- For codes that include refill of pump, the patient must be positioned and the nurse assists to maintain patient position and proper exposure Patient is prepped and draped for sterile procedure.
- Since Schedule II narcotics are involved, a second staff member must verify the prescription verification obtained from storage prior to filling the pump
- Nurse facilitates sterile aspiration of medication into injection syringe(s). The access port is identified through the use of palpation and templates provided in the refill kit. Appropriate technique is used to ensure that medication is delivered into the pump reservoir
- Staff holds the transducer in position while physician reprograms the device. Two clinicians are always required during the actual performance of the refill.
- Since Schedule II narcotics are involved any wastage of medication needs to be witnessed and signed in the logbook
- The room is cleaned and the device must be cleaned antiseptically and stored.
- For codes with refill of pump, vital signs are obtained and patients are monitored for 15 minutes before leaving the office.
- Skin is cleansed and bandages placed.
- Patients are counseled regarding precautions

Post-Service Clinical Labor Activities:

- All patients are called the evening of the service to verify patient status and to evaluate patient's perception and evaluation of pump function.

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified as part of the MPC List Screen

April 2011

Evaluation of Wheezing

In July 2010, CMS identified code 94060 *Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration* as part of the MPC List screen. In February 2011, the RUC recommended that this service be surveyed.

The RUC reviewed the survey results from 48 pulmonary physicians and determined that the current work RVU of 0.31 be maintained as it appropriately accounts for the work required to perform this service. This value is further supported by the survey 25th percentile work RVU of 0.31. The RUC compared 94060 to key reference service 94375 *Respiratory flow volume loop* (work RVU = 0.31) and determined that the surveyed time and that of the key reference service were the same, requiring similar intensity and complexity to perform. However, 94060 is typically billed with an Evaluation and Management service. Therefore, the RUC recommends reducing the pre-service time to 3 minutes, maintaining the survey respondents intra-service time of 7.5 minutes and reducing the immediate post-service time to 3 minutes. For further support the RUC referenced similar service 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVU = 0.30), which has similar intra-service time of 7 minutes and analogous intensity. **The RUC recommends a work RVU of 0.31 for CPT code 94060.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Do not report 94060 in conjunction with 94728, 94150, 94200, 94375)	XXX	0.31 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94060 Tracking Number Original Specialty Recommended RVU: **0.31**
Presented Recommended RVU: **0.31**
Global Period: XXX RUC Recommended RVU: **0.31**

CPT Descriptor: Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Report bronchodilator supply separately with 99070 or appropriate supply code) (For prolonged exercise test for bronchospasm with pre- and post-spirometry, use 94620)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old with a history of chronic obstructive bronchitis and emphysema is seen on a subsequent outpatient visit for increasing shortness of breath.

Percentage of Survey Respondents who found Vignette to be Typical: 79.17%

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:
- Review results of previous Pulmonary Function Testing
- Review order request and diagnosis to ensure that ordered tests were performed
- Review accuracy of race, gender, age, height and smoking status

Description of Intra-Service Work:
- Verify that predicted values are correct for the patient tested
- Review spirometry curves for effort and consistency and errors in the 3-8 maneuvers both pre and post bronchodilator
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:
- Review transcribed report, checking for errors and sign the corrected report. .

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS				
Specialty(s):	American College of Chest Physicians and the American Thoracic Society				
CPT Code:	94060				
Sample Size: 153	**Resp N:** 48	**Response:** 31.3 %			
Sample Type: Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	50.00	**125.00**	500.00	3500.00
Survey RVW:	0.15	0.31	**0.40**	0.62	3.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	4.75	**7.50**	15.00	30.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	94060	**Recommended Physician Work RVU: 0.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**0.00**	**3.00**
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:		**7.50**		

Immediate Post Service-Time:	**3.00**	
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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
94375	XXX	0.31	**RUC Time**

CPT Descriptor Respiratory flow volume loop

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,256,953

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94621	XXX	1.42	**RUC Time**	9,849

CPT Descriptor 2 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

Other Reference CPT Code	Global	Work RVU	Time Source

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:** 29.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 94060**	**Key Reference CPT Code:** 94375	**Source of Time** **RUC Time**
Median Pre-Service Time	3.00	5.00	
Median Intra-Service Time	7.50	7.00	
Median Immediate Post-service Time	3.00	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 Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**13.50**	**17.00**	

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	2.93	2.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.07	2.79
Urgency of medical decision making	2.93	2.79
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.86	2.79
Physical effort required	2.00	2.07
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.21	2.00
Outcome depends on the skill and judgment of physician	3.00	2.86
Estimated risk of malpractice suit with poor outcome	2.38	2.36

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.50	2.36
Intra-Service intensity/complexity	2.50	2.36
Post-Service intensity/complexity	3.21	3.07

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 Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

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) typically reported with an Evaluation and Management service.

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) 94060

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 Pulmonary Disease	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? 3693216
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Extrapolated Medicare frequency by assuming that Medicare Frequency is 33.33% of the size of national frequency. Also, our assumption is using the same ratios as the Medicare data.

Specialty Pulmonary Disease	Frequency 1936353	Percentage 52.42 %
Specialty Internal Medicine	Frequency 794781	Percentage 21.52 %
Specialty Family Practice	Frequency 330174	Percentage 8.94 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,231,072 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2009 Medicare Frequency from RUC Database

Specialty Pulmonary Disease	Frequency 645451	Percentage 52.42 %
Specialty Internal Medicine	Frequency 264927	Percentage 21.52 %
Specialty Family Practice	Frequency 110058	Percentage 8.94 %

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

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 94060

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2011

Lung Resection Procedures

The Society of Thoracic Surgeons (STS) brought forward the lung resection codes voluntarily as part of a major re-organization project to ensure accurate coding and reimbursement for these procedures. In February 2011, CPT Editorial Panel deleted 8 codes, revised 5 codes and created 18 new codes to describe new thoracoscopic procedures and to clarify coding confusion between lung biopsy and lung resection procedures. For the wedge resction procedures, the revisions were based on three tiers; first, the approach, thoracotomy or thoracoscopy; second, the target to remove nodules or infiltrates; and lastly the intent, diagnostic or therapeutic (for nodules only, all infiltrates will be removed for diagnostic purposes).

The coding restructuring and clarification for this family of codes is estimated to result in an overall Medicare work savings of 9 percent compared to the current reporting of these services. The RUC intends to re-examine the volume of these services in three years to confirm the frequency estimates.

The specialty society described the typical patient receiving these services, explaining that the sicker and more complicated patient will typically receive a thoracotomy rather than a thoracoscopy because he/she would most likely not tolerate the intentional collapse of one lung, which is required in order to perform a thoracoscopy. The specialty also noted that removing an infiltrate involves the entire lung, but is less difficult than the removal of a nodule. To remove infiltrates the upper and or lower superficial part of the lung is removed and then examined for infiltrates. Removing a nodule is more difficult, because the nodule is invisible, deeper and harder to resect as the physician must search for a "blip" or protrusion on the lung in order to detect and resect.

32096 ***Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral***
The RUC reviewed the survey results from 84 thoracic surgeons and determined that the survey 25th percentile work RVU of 17.00 and the specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared the physician work of 32096 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32096 is more intense and complex to perform and requires more total time to complete than 32662, 436 and 350 minutes total time, respectively. For further support, the RUC referenced similar services, 45160 *Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach* (work RVU = 16.33 and 342 minutes total time) and 61154 *Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural* (work RVU = 17.07 and 447 minutes total time). **The RUC recommends a work RVU of 17.00 for CPT code 32096.**

32097 ***Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral***
The RUC reviewed the survey results from 83 thoracic surgeons and determined that the survey 25th percentile work RVU of 17.00 and specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared the physician work 32097 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32097 is more intense and complex to perform and requires more total time to complete than 32662, 401 and 350 minutes total time, respectively. For further support the RUC referenced similar services, MPC codes 43832 *Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)* (work RVU = 17.34 and 417 minutes total time) and 44700 *Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)* (work RVU = 17.48 and 402 minutes total time). The specialty society indicated that 32097 is slightly more intense and complex than 32096 however, the survey 25th percentile work RVU was 17.00 for both. **The RUC recommends a work RVU of 17.00 for CPT code 32097.**

32098 ***Thoracotomy, with biopsy(ies) of pleura***
The RUC reviewed the survey results from 84 thoracic surgeons and determined that the survey 25th percentile work RVU of 14.99 and specialty society recommended time appropriately accounts for the physician work and time required to perform this procedure. The RUC compared 32098 to key reference service 32651 *Thoracoscopy, surgical; with partial pulmonary decortication* (work RVU = 18.78) and determined that the key reference service requires more physician work and significantly more total time, 341 and 502 minutes, respectively. The RUC then compared 32098 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32098 requires the same work and similar time to perform, 341 and 350 minutes total time, respectively. For further support the RUC referenced similar service, 58260 *Vaginal hysterectomy, for uterus 250 g or less;* (work RVU = 14.15 and 311 minutes total time) and 27216 *Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)* (work RVU = 15.73 and 393 minutes total time). **The RUC recommends a work RVU of 14.99 for CPT code 32098.**

32100 ***Thoracotomy; with exploration***
The specialty society indicated and the RUC agreed that the patient population and technology has changed for this service since it was last reviewed 10 years ago. Patients for this procedure include those in which perioperative imaging does not delineate if the patient has a resectable central lung cancer. An exploratory thoracotomy is carried out with intraopertive findings that deem the patient unresectable. The RUC reviewed the survey results from 85 thoracic surgeons and determined that a work RVU of 17.00 and specialty society recommended intra time of 90 minutes, total time of 411 minutes, appropriately account for the work and physician time required to perform this procedure. The RUC determined that 32100 is similar to new codes 32096 and 32096, which the RUC is recommending 17.00 for each of these services. The RUC noted that the survey 25th percentile work RVU of 17.50 is similar but could not justify a higher value for 32100. The RUC also compared 32100 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32100 requires more work and time to perform, 411 and 350 minutes total time, respectively. The RUC noted that it did not consider there to be a rank order anomaly between 32100 and 32140 *Thoracotomy; with cyst(s) removal, includes pleural procedure when performed* (work RVU = 16.66) because the physician work required to perform 32100 has increased due to the change in the patient population as indicated above. For further support, the

RUC referenced similar services, 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU = 17.61 and 433 minutes total time) and 46710 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach* (work RVU = 17.14 and 370 minutes total time). **The RUC recommends a work RVU of 17.00 for CPT code 32100.**

32505 ***Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial***
The RUC reviewed the survey results from 91 thoracic surgeons and determined that the survey 25th percentile work RVU of 18.79 and specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared 32505 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32505 is more intense and complex to perform and requires more total time to complete than 32662, 427 and 350 minutes total time, respectively. For further support the RUC referenced similar services, 61751 *Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance* (work RVU = 18.79 and 395 minutes total time) and 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy (separate procedure)* (work RVU = 19.35 and 407 minutes total time). **The RUC recommends a work RVU of 18.79 for CPT code 32505.**

32506 ***Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 42 thoracic surgeons and agreed with the survey median intra-service time of 25 minutes, and agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent to 35697 *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery* (work RVU= 3.00 and 30 minutes intra-service time). The RUC recommends a direct crosswalk for physician work and the survey median intra-service time of 25 minutes. **The RUC recommends a work RVU of 3.00 for CPT code 32506.**

32507 ***Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 43 thoracic surgeons and determined that the survey 25th percentile work RVU of 3.78 and specialty society recommended time of 30 minutes intra-service, appropriately account for the work and physician time required to perform this procedure. The RUC compared 32507 to the key reference service 32501 *Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)* (work RVU = 4.68) and agreed with the survey respondents that although 32507 requires 5 more minutes of intra-service time, 30 versus 25 minutes, 32507 is less intense and complex to perform, requiring less technological skill, physical effort and psychological stress. For further support, the RUC referenced similar services, 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 4.12 and 30 minutes total time) and 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)* (work RVU = 4.44 and 30 minutes total time). **The RUC recommends a work RVU of 3.78 for CPT code 32507.**

32601 ***Thoracoscopy, diagnostic, (separate procedure); lung, pericardial sac, mediastinal or pleural space, without biopsy***
The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 60 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, to crosswalk 32601 to 43257 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease* (work RVU = 5.50, intra-service time = 60 and total time = 114). For further support, the RUC also referenced similar service, 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.85 and intra-service time 60 minutes and total time = 140 minutes). **The RUC recommends a work RVU of 5.50 for CPT code 32601.**

32607 ***Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral***
The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 45 minutes. However, the RUC agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed to crosswalk 32607 to 52301 *Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral* (work RVU = 5.50, intra-service time = 45 and total time = 183). For further support, the RUC also referenced similar service, 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.35 and intra-service time 45 minutes). **The RUC recommends a work RVU of 5.50 for CPT code 32607.**

32608 ***Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral***
The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 60 minutes. In addition, the RUC agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. The RUC agreed that 32608 requires more work to biopsy the lung nodules compared to biopsy lung infiltrates in code 32607 (RUC recommended work RVU = 5.50). The RUC compared 32608 to key reference service 31600 *Tracheostomy, planned (separate procedure);* (work RVU = 7.17) and agreed with the survey respondents that the surveyed code is more intense and complex and requires more time to perform than the reference code, 60 and 40 minutes intra-service time, respectively. The RUC compared the incremental differences between the two surveys for 32607 and 32608 and although the work RVUs were overstated (12.50 and 14.00, respectively) the incremental difference was appropriate and maintained rank order between these two services. The RUC recommends a work RVU of 6.84 for code 32608 which maintains rank order among this family of services. For further support, the RUC referenced similar services 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (work RVU = 6.99) and 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* (work RVU = 6.72), both which have the same intra-service time of 60 minutes as surveyed code 32608. **The RUC recommends a work RVU of 6.84 for CPT Code 32608.**

32609 ***Thoracoscopy; with biopsy(ies) of pleura***
The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 45 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent

to 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU 4.58, intra-time = 45 minutes and total time = 150 minutes). Codes and 32609 and 15004 have the same intra-service time of 45 minutes and similar total time, 178 and 150 minutes, respectively. Additionally, the RUC agreed that a work RVU of 4.58 maintains the proper rank order with 32607 and 32608. For further support the RUC referenced code 20902 *Bone graft, any donor area; major or large* (work RVU = 4.58 and intra-service time of 45 minutes). **The RUC recommends a work RVU of 4.58 for CPT code 32609.**

32663 ***Thoracoscopy, surgical; with lobectomy (single lobe)***
The RUC reviewed the survey results from 55 thoracic surgeons and determined that the current work RVU of 24.64, lower than the survey 25th percentile work RVU of 27.23, appropriately accounts for the physician work required to perform this service. The RUC compared 32663 to codes 35351 *Thromboendarterectomy, including patch graft, if performed; iliac* (work RVU = 24.61 and intra-service time = 150 minutes) and 34802 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)* (work RVU = 23.79 and intra-service time = 150 minutes) and determined that 32673 requires similar intra-service time, 155 and 150 minutes, respectively, as well as similar intensity and complexity to perform. The RUC recommends maintaining the current work RVU of 24.64 for code 32663. **The RUC recommends a work RVU of 24.64 for CPT code 32663.**

32666 ***Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral***
The RUC reviewed the survey results from 55 thoracic surgeons and determined that the survey 25th percentile work RVU of 14.50 and specialty society recommended intra-service time of 75 minutes appropriately account for the work and physician time required to perform this procedure. The RUC compared 32666 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32666 requires less time to perform, 317 and 350 minutes total time, respectively. For further support the RUC referenced similar service, 21685 *Hyoid myotomy and suspension* (work RVU = 15.26 and 75 minutes intra-service time) and 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU = 15.26 and 75 minutes intra-service time). **The RUC recommends a work RVU of 14.50 for CPT code 32666.**

32667 ***Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 25 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent to codes 32506 (RUC recommended work RVU = 3.00 and intra-service time = 25 minutes), 35697 *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery* (work RVU 3.00 and 30 minutes intra-service time) and 15157 *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (*work RVU 3.00 and 30 minutes intra-service time). The RUC recommends a direct crosswalk for physician

work to the aforementioned codes and the survey median intra-service time of 25 minutes. **The RUC recommends a work RVU of 3.00 for CPT code 32667.**

32668 ***Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 44 thoracic surgeons and determined that the survey 25th percentile work RVU of 4.00 and 30 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32668 to code 32507 *Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection* (RUC recommended work RVU = 3.78) and determined that the additional work for 32668 accounts for the increased intensity and complexity to perform the thoracoscopy and maintains the proper rank order among these services. For further support the RUC referenced codes 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)* (work RVU = 4.44) and 61641 *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family (List separately in addition to code for primary procedure)* (work RVU = 4.33) both which have the same time of 30 minutes as surveyed code 32668. **The RUC recommends a work RVU of 4.00 for CPT code 32668.**

32669 ***Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)***
The RUC reviewed the survey results from 54 thoracic surgeons and agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work and intra-service time of 150 minutes required to perform this service is equivalent to 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)* (work RVU=23.53 and intra-time = 150 minutes). The RUC also agreed that a work RVU of 23.53 maintains the appropriate rank order and incremental difference between the 25th percentile survey results for 32669 and 32663 (26.00 divided by 27.23 work RVUs x 24.64 work RVUs for 32663 = 23.53). For further support, the RUC referenced similar service 58200 *Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)* (work RVU = 23.10 and intra-service time = 150 minutes). **The RUC recommends a work RVU of 23.53 for CPT code 32669.**

32670 ***Thoracoscopy, surgical; with removal of two lobes (bilobectomy)***
The RUC reviewed the survey results from 55 thoracic surgeons and agreed with the survey median intra-service time of 180 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 34451 *Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision* (work RVU = 28.52 and 180 minutes intra-service time). The RUC recommends a direct crosswalk to code 34451 for physician work. **The RUC recommends a work RVU of 28.52 for CPT code 32670.**

32671 ***Thoracoscopy, surgical; with removal of lung (pneumonectomy)***
The RUC reviewed the survey results from 55 thoracic surgeons and determined that the survey 25th percentile work RVU of 31.92 and 180 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32671 to code 32652 *Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis* (work RVU = 29.13) and determined that 32671 is more intense and complex and requires more physician time to perform than 32652, 180 and 160 minutes intra-service time, respectively. For further support the RUC referenced codes 35251 *Repair blood vessel with vein graft; intra-abdominal* (work RVU = 31.91) and 33507 *Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation* (work RVU = 31.40) both which have the same intra-service time as surveyed code 32671, 180 minutes. **The RUC recommends a work RVU of 31.92 for CPT code 32671.**

32672 ***Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed***
The RUC reviewed the survey results from 54 thoracic surgeons and determined that the survey 25th percentile work RVU of 27.00 and 120 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32672 to key reference code 32141 *Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure* (work RVU = 27.18) and determined that 32672 requires similar physician work and time to perform, 116 and 120 minutes, respectively. For further support, the RUC referenced codes 43880 *Closure of gastrocolic fistula* (work RVU = 27.18) and 43502 *Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)* (work RVU = 25.69) both which have the same intra-service time as surveyed code 32672, 120 minutes. **The RUC recommends a work RVU of 27.00 for CPT code 32672.**

32673 ***Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral***
The RUC reviewed the survey results from 54 thoracic surgeons and determined that the survey 25th percentile work RVU of 21.13 and 150 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32673 to codes 35302 *Thromboendarterectomy, including patch graft, if performed; superficial femoral artery* (work RVU = 21.35) and 22905 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greater* (work RVU = 21.58) and determined that 32673 requires the same intra-service time of 150 minutes and similar intensity and complexity to perform. **The RUC recommends a work RVU of 21.13 for CPT code 32673.**

32674 ***Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 30 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (work RVU = 4.12 and 30 minutes intra-service time). The RUC recommends a direct crosswalk to code 34826 for physician work. **The RUC recommends a work RVU of 4.12 for CPT code 32674.**

38746 ***Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 30 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (work RVU = 4.12 and 30 minutes intra-service time). The RUC recommends a direct crosswalk to code 34826 for physician work. **The RUC recommends a work RVU of 4.12 for CPT code 38746.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC recommends the direct practice expense inputs recommended by the specialty society for these procedures performed in the facility setting.

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Respiratory System** **Lungs and Pleura** Pleural cavity or lung biopsy procedures may be accomplished using a percutaneous, thoracoscopic (Video-Assisted Thoroscopic Surgery [VATS]), or thoracotomy approach. They involve the removal of differing amounts of tissue for diagnosis. A biopsy may be performed using different techniques such as incision or wedge. Lung resection procedures include diagnostic and therapeutic procedures, including the removal of blebs, bullae, cysts, and benign or malignant tumors or lesions. These procedures may involve the removal of small portions of the lung or even an entire lung. Additionally, lung resection procedures may require the removal of adjacent structures. Both diagnostic lung biopsies and therapeutic lung resections can be performed utilizing a wedge technique. However, a diagnostic biopsy of a lung nodule using a wedge technique requires only that a tissue sample be obtained without particular attention to resection margins. A therapeutic wedge resection requires attention to margins and complete resection even when the wedge resection is ultimately followed by a more extensive resection. In the case of a wedge resection where intraoperative pathology consultation determines that a more extensive resection is required				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
in the same anatomic location, it becomes classified as a diagnostic wedge resection (32507, 32668). When no more extensive resection is required, the same procedure is a therapeutic wedge resection (32505, 32666). Pleural or lung biopsies or diagnostic wedge resections should be reported using codes 32096, 32097, 32098, 32400, 32405, 32507, 32607, 32608, 32609 or 32668. The open or thoracoscopic (VATS) therapeutic resection of lung mass or nodules via a wedge resection is reported using codes 32505, 32506, 32666, and 32667. More extensive anatomic lung resection procedures, which can be performed with either thoracotomy or thoracoscopic (VATS) approaches, include: segmentectomy, lobectomy, bilobectomy, and pneumonectomy. When diagnostic biopsy(ies) of the lung are performed, regardless of the approach (ie open or thoracoscopic (VATS)), or technique (eg, incisional resection, cautery resection, or stapled wedge), and the specimen is sent for intraoperative pathology consultation, and during that same operative session the surgeon uses these results to determine the extent of the necessary surgical resection that includes the anatomical location biopsied, only the most extensive procedure performed (eg, segmentectomy, lobectomy, thoracoscopic (VATS) lobectomy) should be reported. The therapeutic wedge resection codes (32505, 32506, 32666, or 32667) should not be reported in addition to the more extensive lung procedure (eg, lobectomy) unless the therapeutic wedge resection was performed on a different lobe or on the contralateral lung, whether or not an intraoperative pathology consultation is used to determine the extent of lung resection. When a diagnostic wedge resection is followed by a more extensive procedure in the same anatomical location, report add-on codes 32507 or 32668 with the more extensive procedure(s). When a therapeutic wedge resection (32505, 32506, 32666, or 32667) is performed in a different lobe than the more extensive lung resection (eg lobectomy), report the therapeutic wedge resection with modifier 59 **Incision** (32000 has been deleted. To report, use 32421) (32002 has been deleted. To report, use 32422) (32005 has been deleted. To report, use 32560) (32019 has been deleted. To report, use 32550)				

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(32020 has been deleted. To report, use 32551) (To report wound exploration due to penetrating trauma without thoracotomy, use 20101)				
D 32095		~~Thoracotomy, limited, for biopsy of lung or pleura~~ (32095 has been deleted. To report, see 32096, 32097, 32098 for thoracotomy with biopsy of the lung or pleura)	090	N/A
●32096	II1	Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral (Do not report 32096 more than once per lung) (Do not report 32096 in conjunction with 32440, 32442, 32445, 32488)	090	17.00
●32097	II2	Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral (Do not report 32097 more than once per lung) (Do not report 32097 in conjunction with 32440, 32442, 32445, 32488)	090	17.00
●32098	II3	Thoracotomy, with biopsy(ies) of pleura	090	14.99
▲32100	II4	Thoracotomy, ~~major~~; with exploration ~~and biopsy~~ (Do not report 32100 in conjunction with 19260, 19271, 19272, 32503, 32504)	090	17.00

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
E 32140		with cyst(s) removal, ~~with or without a~~ includes pleural procedure when performed	090	16.66 (No Change)
E 32141		with ~~excision~~ resection-plication of bullae~~, with or without~~ includes any pleural procedure when performed (For lung volume reduction, use 32491)	090	27.18 (No Change)
Excision/Resection				
E 32400		Biopsy, pleura; percutaneous needle (If imaging guidance is performed, see 76942, 77002, 77012, 77021) (For fine needle aspiration, use 10021 or 10022) ~~(For evaluation of fine needle aspirate, see 88172, 88173)~~	000	1.76 (No Change)
D 32402		~~open~~ (32402 has been deleted. To report open biopsy of pleura, use code 32098)	090	N/A
E 32405		Biopsy, lung or mediastinum, percutaneous needle (For open biopsy of lung see 32096-32097. For open biopsy of mediastinum see 39000 or 39010. For thoracoscopic (VATS) biopsy of lung, pleura, pericardium or mediastinal space structure see 32604, 32606, 32607, 32608, 32609) (For radiological supervision and interpretation, see 76942, 77002, 77012, 77021) (For fine needle aspiration, use 10022) ~~(For evaluation of fine needle aspirate, see 88172, 88173)~~	000	1.93 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Removal				
E 32421		Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent (If imaging guidance is performed, see 76942, 77002, 77012) ~~(For total lung lavage, use 32997)~~	000	1.54 (No Change)
E 32440		Removal of lung, ~~total~~ pneumonectomy;	090	27.28 (No Change)
E 32442		with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	090	56.47 (No Change)
E 32445		extrapleural (For extrapleural pneumonectomy, with empyemectomy, use 32445 and 32540) (If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection ~~code~~ 19260-19272, in addition to lung resection ~~code~~ 32440-32445)	090	63.84 (No Change)
E 32480		Removal of lung, other than ~~total~~ pneumonectomy; single lobe (lobectomy)	090	25.82 (No Change)
E 32482		2 lobes (bilobectomy)	090	27.44 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
E 32484		single segment (segmentectomy) (For removal of lung with bronchoplasty, use 32501)	090	25.38 (No Change)
E 32486		with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)	090	42.88 (No Change)
E 32488		with all remaining lung following previous removal of a portion of lung (completion pneumonectomy) (For ~~total~~ lobectomy or segmentectomy~~al lobectomy~~, with concomitant decortication, use 32320 and the appropriate removal of lung code)	090	42.99 (No Change)
E 32491		with ~~excision~~ resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes ~~with or without~~ any pleural procedure, when performed	090	25.24 (No Change)
D 32500		~~wedge resection, single or multiple~~ (32500 has been deleted. To report open wedge resection of lung see 32505, 32506, 32507)	090	N/A
32504		Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction (Do not report 32503, 32504 in conjunction with 19260, 19271, 19272, 32100,	090	36.54 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		32422, 32551) ~~(For performance of lung resection in conjunction with chest wall resection, see 19260, 19271, 19272 and 32480 32500, 32503, 32504)~~		
●32505	II5	Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial (Do not report 32505, in conjunction with 32440, 32442, 32445, 32488)	090	18.79
● +32506	II6	with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure) (Report 32506 only in conjunction with 32505) (If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection 19260-19272, in addition to lung resection 32480, 32482, 32484, 32486, 32488, 32505, 32506, 32507)	ZZZ	3.00
●+32507	II7	with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure) (Report 32507 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504)	ZZZ	3.78
Thoracoscopy (VATS-video-assisted thoracic surgery) Surgical thoracoscopy (VATS-video-assisted thoracic surgery) always includes diagnostic thoracoscopy. ~~For endoscopic procedures, code appropriate endoscopy of each anatomic site examined.~~				
▲32601	II8	Thoracoscopy, diagnostic, (separate procedure); lung, pericardial sac, mediastinal or pleural space, without biopsy	000	5.50 (No Change)
D 32602		~~lungs and pleural space, with biopsy~~	000	N/A

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(32602 has been deleted. To report lung or pleural space biopsy(ies), see 32607, 32608, 32609)		
D 32603		~~pericardial sac, without biopsy~~ (32603 has been deleted. To report diagnostic thoracoscopy, pericardial sac, without biopsy use 32601)	000	N/A
E 32604		pericardial sac, with biopsy (For open pericardial biopsy, use 39010)	000	8.77 (No Change)
D 32605		~~mediastinal space, without biopsy~~ (32605 has been deleted. To report diagnostic thoracoscopy within the mediastinal space, use 32601)	000	N/A
E 32606		mediastinal space, with biopsy	000	8.39 (No Change)
●32607	II9	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral (Do not report 32607 more than once per lung) (Do not report 32607 in conjunction with~~,~~ 32440, 32442, 32445, 32488, 32671)	000	5.50
●32608	II10	with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral (Do not report 32608 more than once per lung) (Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)	000	6.84

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
●32609	II11	with biopsy(ies) of pleura	000	4.58
E 32655		Thoracoscopy, surgical; with ~~excision~~ resection-plication of bullae, includes~~ing~~ any pleural procedure when performed (For thoracoscopic (VATS) lung volume reduction surgery, use 32672)	090	16.17 (No Change)
D 32657		~~with wedge resection of lung, single or multiple~~ (32657 has been deleted. To report thoracoscopic (VATS) wedge resection of lung, see 32666, 32667, 32668)	090	N/A
D 32660		~~with total pericardiectomy~~ (32660 has been deleted)	090	N/A
▲32663	II16	with lobectomy~~, total or segmental~~ (~~eg~~, single lobe) (For thoracoscopic (VATS) segmentectomy see 32669)	090	24.64 (No Change)
●32666	II12	with therapeutic wedge resection (eg, mass, nodule), initial unilateral (To report bilateral procedure, report 32666 with modifier 50 (Do not report 32666, in conjunction with 32440, 32442, 32445, 32488, 32671)	090	14.50
32665		with esophagomyotomy (Heller type) (For exploratory thoracoscopy, and exploratory thoracoscopy with biopsy, see 32601 -32609)	090	21.53 (No Change)
●+32667	II13	with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	ZZZ	3.00

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(Report 32667 only in conjunction with 32666) (Do not report 32667 in conjunction with 32440, 32442, 32445, 32488, 32671)		
●+32668	II14	with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure) (Report 32668 in conjunction with 32440, 32442, 33245, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32669, 32663, 32670, 32671)	ZZZ	4.00
●32669	II15	with removal of a single lung segment (segmentectomy)	090	23.53
●32670	II17	with removal of two lobes (bilobectomy)	090	28.52
●32671	II18	with removal of lung (pneumonectomy)	090	31.92
●32672	II19	with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed	090	27.00
●32673	II20	with resection of thymus, unilateral or bilateral (For open thymectomy see 60520, 60521, 60522) (For open excision mediastinal cyst see 39200, for open excision mediastinal tumor use 39220)	090	21.13
●+32674	II21	with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure) (On the right, mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament) (On the left, mediastinal lymph nodes include the aortopulmonary window,	ZZZ	4.12

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		subcarinal, paraesophageal, and inferior pulmonary ligament). (Report 32674 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32505, 32503, 32504, 32666, 32667, 32669, 32663, 32670, 32671) (To report mediastinal and regional lymphadenectomy via thoracotomy, use 38746)		
Cardiovascular System **Heart and Pericardium** **Pericardium** (For thoracoscopic (VATS) pericardial procedures see 32601, 32604, 32658, 32659, 32661)				
33025		Creation of pericardial window or partial resection for drainage (For thoracoscopic (VATS) pericardial window, use 32659)	090	13.70 (No Change)
▲33050		~~Excision~~Resection of pericardial cyst or tumor (For open pericardial biopsy use 39010) (For thoracoscopic (VATS) resection of pericardial cyst, tumor or mass use 32661)	090	16.97 (No Change)
Hemic and Lymphatic Systems **Lymph Nodes and Lymphatic Channels** **Radical Lymphadenectomy (Radical Resection of Lymph Nodes)**				
▲+38746	II22	Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy~~, including mediastinal and peritracheal nodes~~ (List separately in	ZZZ	4.12

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
		addition to code for primary procedure) (On the right, mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament) (On the left, mediastinal lymph nodes include the aortopulmonary window, subcarinal, paraesophageal, and inferior pulmonary ligament). (Report 38746 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32505, 32503, 32504) (To report mediastinal and regional lymphadenectomy via thoracoscopy (VATS), see 32674)		
Mediastinum and Diaphragm **Mediastinum**				
E 39010		Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy (For VATS pericardial biopsy, use 32604)	090	13.19 (No Change)
Excision/Resection				
E 39200		~~Excision~~Resection of mediastinal cyst	090	15.09 (No Change)
E 39220		~~Excision~~Resection of mediastinal tumor (For substernal thyroidectomy, use 60270) (For thymectomy, use 60520)	090	19.55 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For thoracoscopic (VATS) resection of mediastinal cyst, tumor or mass use 32662)		
Endoscopy				
E 39400		Mediastinoscopy, ~~with~~ includes ~~or without~~ biopsy(ies), when performed	010	8.05 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32096 Tracking Number II1 Original Specialty Recommended RVU: **17.00**
Presented Recommended RVU: **17.00**
Global Period: 090 RUC Recommended RVU: **17.00**

CPT Descriptor: Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
(Do not report 32096 more than once per lung)
(Do not report 32096 in conjunction with 32440, 32442, 32445, 32488)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year old female intubated patient has worsening hypoxia. Bilateral diffuse pulmonary infiltrates progressively worsen. Bronchoscopy and bronchoalveolar lavage are non-diagnostic. Microbiologic cultures show usual flora. Patient continues to deteriorate from a respiratory standpoint. Open lung biopsy for diagnosis is necessary.

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 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the reason for lung biopsy is discussed with the physicians caring for the patient. Medical records are reviewed including x-rays identifying the most representative areas of the lungs to biopsy. The patient is seen and examined to rule out concurrent illness and any contraindication to surgery. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then positions the patient in a lateral decubitus position and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: An anterolateral thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and palpation of the parietal pleura, visceral pleura, and lung. Abnormalities of the visceral pleura and lung are noted. It is confirmed that a diffuse infiltrative non-localized process is involving the lung. Both abnormal and normal regions of lung are identified and their relationship to the pulmonary vasculature and bronchial tree assessed to determine that biopsy is feasible. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. The lung is mobilized as needed for

assistance in exposing the areas to be biopsied. Using multiple firings of tissue staplers a wedge resection of the lung is performed removing a portion of lung that contains both abnormal and normal lung tissue. Typically, a second wedge resection from a separate portion of the ipsilateral lung is performed in the same manner. Sterile portions of the resected lung tissue are prepared and sent for appropriate microbiologic testing. The remaining portions of resected lung are typically sent for frozen section pathologic evaluation to ensure that adequate biopsy material has been obtained. If not, additional biopsies are taken. As needed, hemostasis is secured with electrocautery and if necessary the staple lines reinforced with suture. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument , needle, and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The patient is brought to the recovery room. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. These patients are usually in an ICU and may also be cared for by an intensivist. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 3-5 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD		
Specialty(s):	The Society of Thoracic Surgeons		
CPT Code:	32096		
Sample Size:	300	**Resp N:** 84	**Response:** 28.0 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**5.00**	10.00	75.00
Survey RVW:	11.00	17.00	**21.30**	27.05	40.00
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	35.00	60.00	**60.00**	90.00	180.00

Immediate Post Service-Time:	**30.00**	
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):	**210.00**	99231x **1.00** 99232x **2.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32096	**Recommended Physician Work RVU: 17.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
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):	**210.00**	99231x **1.00** 99232x **2.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32141	090	27.18	**RUC Time**

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19318	090	16.03	**RUC Time**	6,342

CPT Descriptor 1 Reduction mammaplasty

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
58150	090	17.31	**RUC Time**	15,005

CPT Descriptor 2 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

Other Reference CPT Code	Global	Work RVU	Time Source
32662	090	14.99	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass

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:** 19.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32096**	**Key Reference CPT Code:** 32141	**Source of Time RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	60.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	210.0	345.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	23.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**436.00**	**673.00**	
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	3.50	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.31
Urgency of medical decision making	3.75	2.63
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.06	3.13
Physical effort required	3.06	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.81	3.19
Outcome depends on the skill and judgment of physician	3.69	3.38
Estimated risk of malpractice suit with poor outcome	3.31	3.06

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.38	3.25
Intra-Service intensity/complexity	3.00	2.94
Post-Service intensity/complexity	3.56	3.19

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.*

A survey was conducted with 84 respondents. 32141was selected as the Key Reference Service, and was performed 7 times annually by the respondents, compared to 5 times for the surveyed code. The vignette was felt to be typical by 95% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (60 minutes) and immediate post service time (40 minutes) are recommended, as is a length of stay of 6 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the
survey. The typical patient is seen 1 time in the office setting, with a 99213 recommended by the expert panel.

We are recommending a work RVU of 17.00 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32141, the expert panel felt that 32096 was of similar intensity, had less intraoperative work and had less postoperative work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32095, 32100 or 32500

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 Cardiothoracic Surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1986

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1470 Percentage 74.01 %

Specialty general surgery Frequency 318 Percentage 16.01 %

Specialty other Frequency 199 Percentage 10.02 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,951
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty cardiothoracic surgery Frequency 1444 Percentage 74.01 %

Specialty general surgery Frequency 312 Percentage 15.99 %

Specialty other Frequency 195 Percentage 9.99 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32151

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32097 Tracking Number II2 Original Specialty Recommended RVU: **17.00**
Presented Recommended RVU: **17.00**
Global Period: 090 RUC Recommended RVU: **17.00**

CPT Descriptor: Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
(Do not report 32097 more than once per lung)
(Do not report 32097 in conjunction with 32440, 32442, 32445, 32488)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year old man with a history of smoking presents with a newly discovered lung nodule. The nodule, location is not amenable to either transthoracic needle aspiration or bronchoscopic biopsy. Lung cancer is suspected. At thoracotomy, multiple other small nodules are found throughout both lungs worrisome for metastatic disease.

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 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the worrisome lung nodule. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing. The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. Abnormalities are noted including the presence of multiple small nodules present throughout all of the lung lobes. The small nodules are worrisome for metastatic cancer. The lung is mobilized as needed for assistance in exposing the areas to be biopsied. Using electrocautery a nodule(s) is removed. As necessary hemostasis is secured with electrocautery and if needed the lung parenchymal defect closed with suture. Sterile portions of the resected nodule(s) are prepared and saved for appropriate microbiologic testing. The

remaining portions of the resected lung nodule(s) are sent for frozen section evaluation to obtain a histopathologic diagnosis. Metastatic lung cancer is confirmed. Based upon the number of metastatic nodules observed, the primary tumor is deemed unresectable. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 2-4 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD		
Specialty(s):	The Society of Thoracic Surgeons		
CPT Code:	32097		
Sample Size:	300	**Resp N:** 83	**Response:** 27.6 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	11.00	50.00
Survey RVW:	12.00	17.00	**20.00**	24.69	45.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	40.00	60.00	**80.00**	90.00	200.00

Immediate Post Service-Time:	**30.00**	
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):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32097	**Recommended Physician Work RVU: 17.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**80.00**		

Immediate Post Service-Time:	**30.00**	
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):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32141	090	27.18	**RUC Time**

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19318	090	16.03	**RUC Time**	6,342

CPT Descriptor 1 Reduction mammaplasty

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
58150	090	17.31	**RUC Time**	15,005

CPT Descriptor 2 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

Other Reference CPT Code	Global	Work RVU	Time Source
32662	090	14.99	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass

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:** 21.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 32097**	**Key Reference CPT Code:** 32141	**Source of Time RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	80.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	345.00	
Median Other Hospital Visit Time	155.0	38.00	
Median Discharge Day Management Time	38.0	39.00	
Median Office Visit Time	23.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**401.00**	**673.00**	
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	3.44	2.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.22
Urgency of medical decision making	3.00	2.61
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.22	2.89
Physical effort required	3.06	2.94
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.11	3.17
Outcome depends on the skill and judgment of physician	3.39	3.33
Estimated risk of malpractice suit with poor outcome	3.06	3.11

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.28	3.22
Intra-Service intensity/complexity	3.06	3.06
Post-Service intensity/complexity	3.11	3.22

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.*

A survey was conducted with 83 respondents. 32141 was selected as the Key Reference Service, and was performed 5 times annually by the respondents, compared to 5 times for the surveyed code. The vignette was felt to be typical by 94% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (80 minutes) and immediate post service time (30 minutes) are recommended, as is a length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 1 time in the office setting, with a 99213 recommended by the expert panel.

We are recommending a work RVU of 17.00 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32141, the expert panel felt that 32097 had less intraoperative work, less postoperative work and one less office visit.

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) 32095, 32100 and 32500

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1986

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1470 Percentage 74.01 %

Specialty general surgery Frequency 318 Percentage 16.01 %

Specialty other Frequency 199 Percentage 10.02 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,951
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty cardiothoracic surgery Frequency 1444 Percentage 74.01 %

Specialty general surgery Frequency 429 Percentage 21.98 %

Specialty other Frequency 78 Percentage 3.99 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32151

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32098 Tracking Number II3 Original Specialty Recommended RVU: **14.99**
Presented Recommended RVU: **14.99**
Global Period: 090 RUC Recommended RVU: **14.99**

CPT Descriptor: Thoracotomy, with biopsy(ies) of pleura

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man presents with chest pain and diffuse pleural thickening.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the abnormally thickened pleura. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered. It may be necessary to remove a segment of rib for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing. The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. Pleural abnormalities are noted. The lung is retracted as needed for assistance in exposing the areas to be biopsied. The worrisome portions of the pleura are assessed for feasibility of biopsy. Using biopsy forceps or scalpel, pleural biopsies are performed removing at least 1 cm portions of pleura. As necessary hemostasis is secured with electrocautery. Sterile portions of the resected pleura are prepared and saved for appropriate microbiologic testing. The remaining portions of resected pleura are sent for frozen section evaluation to ensure adequate tissue has been obtained, and if possible to obtain histopathologic diagnosis. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle,

and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 1-2 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD		
Specialty(s):	The Society of Thoracic Surgeons		
CPT Code:	32098		
Sample Size:	300	**Resp N:** 84	**Response:** 28.0 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**3.00**	6.00	40.00
Survey RVW:	10.00	14.99	**18.00**	22.85	40.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	23.00	59.00	**60.00**	90.00	180.00

Immediate Post Service-Time:	**30.00**	
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):	**115.00**	99231x **1.00** 99232x **1.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32098	**Recommended Physician Work RVU: 14.99**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
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):	**115.00**	99231x **1.00** 99232x **1.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32651	090	18.78	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with partial pulmonary decortication

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63030	090	13.18	**RUC Time**	36,671

CPT Descriptor 1 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
24430	090	15.25	**RUC Time**	653

CPT Descriptor 2 Repair of nonunion or malunion, humerus; without graft (eg, compression technique)

Other Reference CPT Code	Global	Work RVU	Time Source
32662	090	14.99	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass

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:** 23.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 32098**	**Key Reference CPT Code:** 32651	**Source of Time RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	60.00	70.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	115.0	220.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	23.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**341.00**	**502.00**	

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	2.53	2.63
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.84	2.74
Urgency of medical decision making	2.47	3.05
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.37	3.16
Physical effort required	2.47	3.00
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.37	2.68
Outcome depends on the skill and judgment of physician	2.47	3.05
Estimated risk of malpractice suit with poor outcome	2.37	2.26

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.68	3.26
Intra-Service intensity/complexity	2.32	3.00
Post-Service intensity/complexity	2.37	2.95

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.*

A survey was conducted with 84 respondents. 32651 was selected as the Key Reference Service, and was performed 6 times annually by the respondents, compared to 3 times for the surveyed code. The vignette was felt to be typical by 90% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (60 minutes) and immediate post service time (30 minutes) are recommended, as is a length of stay of 4 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 1 time in the office setting, with a 99213 recommended by the expert panel.

We are recommending a work RVU of 14.99 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32651, the expert panel felt 32098 had less intraoperative work, less postoperative care, and 1 less office visit.

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) 32402

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 430

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 353 Percentage 82.09 %

Specialty general surgery Frequency 36 Percentage 8.37 %

Specialty other Frequency 41 Percentage 9.53 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 323
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 frequency for code 32402 (323) will transfer 100% to the new code.

Specialty cardiothoracic surgery Frequency 265 Percentage 82.04 %

Specialty general surgery Frequency 27 Percentage 8.35 %

Specialty other Frequency 31 Percentage 9.59 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32662

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32100 Tracking Number II4 Original Specialty Recommended RVU: **17.50**
Presented Recommended RVU: **17.50**
Global Period: 090 RUC Recommended RVU: **17.00**

CPT Descriptor: Thoracotomy, major; with exploration and biopsy
(Do not report 32100 in conjunction with 19260, 19271, 19272, 32503, 32504)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 65 yo woman with biopsy proven hilar lung cancer and limited lung function who would not tolerate pneumonectomy is explored through a thoracotomy. There is no evidence of pleural or mediastinal nodal metastases. The tumor is found to involve both the superior and inferior pulmonary veins and can only be resected completely if pneumonectomy is performed therefore the patient is unfortunately deemed unresectable and the thoracotomy is closed

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 1%

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 100%

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)?

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the abnormally enlarged hilum. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient The pre-incision surgical pause is completed.

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing. The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. Abnormalities are noted but no biopsies are performed. Prior to dissecting out the lobar vessels, the main pulmonary artery is dissected out and encircled with vascular tapes in anticipation of performing a difficult lobar dissection. In addition, the appropriate pulmonary vein is dissected out, encircled with vascular tapes. The major fissure is dissected out and the fissure is divided with several applications of the

stapling device. The interlobar pulmonary artery branches are dissected out and encircled with vascular tapes. Unfortuantely the tumor is found to involve the main interlobar pulmonary artery and the patient is deemed unresectable given the patient's limited lung function. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 2-4 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011		
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD		
Specialty(s):	The Society of Thoracic Surgeons		
CPT Code:	32100		
Sample Size:	300	**Resp N:** 85	**Response:** 28.3 %
Sample Type:	Random	**Additional Sample Information:**	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**3.00**	5.00	15.00
Survey RVW:	13.88	17.50	**24.00**	29.00	45.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	30.00	60.00	**90.00**	120.00	195.00

Immediate Post Service-Time:	**30.00**	
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):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32100	**Recommended Physician Work RVU: 17.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
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):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32141	090	27.18	**RUC Time**

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
58150	090	17.31	**RUC Time**	15,005

CPT Descriptor 1 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
49002	090	17.63	**RUC Time**	5,836

CPT Descriptor 2 Reopening of recent laparotomy

Other Reference CPT Code	Global	Work RVU	Time Source
32662	090	14.99	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass

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:** 20.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32100**	**Key Reference CPT Code:** 32141	**Source of Time RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	90.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	155.0	345.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	23.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**411.00**	**673.00**	
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	3.76	2.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	2.71
Urgency of medical decision making	3.53	2.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.59	3.06
Physical effort required	3.47	2.94
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.65	2.94
Outcome depends on the skill and judgment of physician	4.06	3.12
Estimated risk of malpractice suit with poor outcome	3.00	2.59

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.82	3.00
Intra-Service intensity/complexity	3.76	2.94
Post-Service intensity/complexity	3.29	3.06

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.*

A survey was conducted with 85 respondents. 32141 was selected as the Key Reference Service, and was performed 6 times annually by the respondents, compared to 3 times for the surveyed code. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (90 minutes) and immediate post service time (_30 minutes) are recommended, as is a length of stay of 5_days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 1 times in the office setting, with a 99213 recommended by the expert panel.

We are recommending a work RVU of 17.00 for this code. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32141, the expert panel felt that 32100 had less intraoperative work but was of similar intensity, less postoperative work and less office visits.

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) 32100

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 637

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 510 Percentage 80.06 %

Specialty general surgery Frequency 72 Percentage 11.30 %

Specialty other Frequency 55 Percentage 8.63 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 479
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that of the 2009 frequency for code 32100 will shift to new codes 32096 and32097 and that 25% of the procedures will still be reported under code 32100

Specialty cardiothoracic surery Frequency 383 Percentage 79.95 %

Specialty general surgery Frequency 54 Percentage 11.27 %

Specialty other Frequency 41 Percentage 8.55 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32660

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32505 Tracking Number II5 Original Specialty Recommended RVU: **18.79**
Presented Recommended RVU: **18.79**
Global Period: 090 RUC Recommended RVU: **18.79**

CPT Descriptor: Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial

(Do not report 32505, in conjunction with 32440, 32442, 32445, 32488)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male nonsmoker with a history of resected colon cancer and adjuvant chemotherapy is found to have a growing right pulmonary nodule. There is no evidence of locally recurrent colon cancer or intra-abdominal metastatic disease. There is no mediastinal lymphadenopathy or evidence of other pulmonary nodules. Pulmonary function is normal. Metastatic colon cancer to the right lung is suspected.

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 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the abnormal lung nodule. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing.
The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. Abnormalities are noted. The worrisome lung nodule is located and its relationship to the pulmonary vasculature and bronchial tree assessed to determine if resection is feasible. The lung is mobilized as necessary for assistance in exposing the nodule. Using multiple firings of tissue staplers a wedge resection of the nodule is performed

removing the nodule with at least a 1- to 2 cm free margin of normal lung parenchyma. As necessary hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture. Sterile portions of the resected nodule are prepared and sent for if appropriate microbiologic testing. The remaining portions of resected lung are sent for frozen section evaluation to obtain a histopathologic diagnosis and confirm a clean margin. If cancer is confirmed, then thoracic lymphadenectomy may be indicated. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery.. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 2-4 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32505				
Sample Size:	300	**Resp N:**	91	**Response:** 30.3 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**10.00**	19.00	60.00
Survey RVW:	12.00	18.79	**23.18**	27.00	40.00
Pre-Service Evaluation Time:			**55.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	42.00	68.00	**90.00**	90.00	210.00

Immediate Post Service-Time:	**30.00**	
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):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32505	**Recommended Physician Work RVU: 18.79**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**90.00**		

Immediate Post Service-Time:	**30.00**	
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):	**155.00**	99231x **1.00** 99232x **2.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32141	090	27.18	**RUC Time**

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
50220	090	18.68	**RUC Time**	1,706

CPT Descriptor 1 Nephrectomy, including partial ureterectomy, any open approach including rib resection;

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
38100	090	19.55	**RUC Time**	2,817

CPT Descriptor 2 Splenectomy; total (separate procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
32662	090	14.99	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass

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:** 30.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 32505**	**Key Reference CPT Code:** 32141	**Source of Time** RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	90.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	155.0	345.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**427.00**	**673.00**	

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	3.57	2.96
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.54
Urgency of medical decision making	2.96	2.82
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.29	3.18
Physical effort required	3.36	3.21
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.00	3.36
Outcome depends on the skill and judgment of physician	3.43	3.68
Estimated risk of malpractice suit with poor outcome	3.50	3.50

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.39	3.54
Intra-Service intensity/complexity	3.14	3.32
Post-Service intensity/complexity	3.25	3.61

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.*

A survey was conducted with 91 respondents. 32662 was selected as the Key Reference Service, and was performed 6 times annually by the respondents, compared to 10 times for the surveyed code. The vignette was felt to be typical by 92% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (90 minutes) and immediate post service time (30 minutes) are recommended, as it a length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the
survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 18.79 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32141, the expert panel felt 32505 had more complex intraoperative decision making associated with it with regards to sparing the appropriate amount of lung and corresponding bronchovascular structures when doing the wedge resection and simultaneously ensuring negative margins to properly remove the cancer. The postoperative care is more intense due to management of air leaks from the staple lines. Two postoperative visits are required to adequately manage the incisional pain, remove sutures, review the chest radiograph, and discuss the pathology report with the patient and communicate with the referring oncologist for possible additional adjuvant therapy and follow-up.

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) 32500

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 8630
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 7218 Percentage 83.63 %

Specialty general surgery Frequency 869 Percentage 10.06 %

Specialty other Frequency 543 Percentage 6.29 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,375
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. For the therapeutic wedge resection procedures, it is estimated that the current frequency from 32500 (6489) will shift to the new codes 32055 and +32507.

Specialty cardiothoracic surgery Frequency 3658 Percentage 83.61 %

Specialty general surgery Frequency 438 Percentage 10.01 %

Specialty other Frequency 279 Percentage 6.37 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32651

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32506 Tracking Number II6 Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **3.50**
Global Period: ZZZ RUC Recommended RVU: **3.00**

CPT Descriptor: Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)
(Report 32506 only in conjunction with 32505)
(If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection 19260-19272, in addition to lung resection 32480, 32482, 32484, 32486, 32488, 32505, 32506, 32507)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male nonsmoker with a history of resected colon cancer and adjuvant chemotherapy is found to have a growing right upper lobe pulmonary nodule. There is no evidence of locally recurrent colon cancer or intra-abdominal metastatic disease. There is no mediastinal lymphadenopathy but an additional pulmonary nodule within the lower lobe is found. Pulmonary function is normal. Metastatic colon cancer to the right lung is suspected. The patient has a right thoracotomy with wedge resection of the right upper lobe nodule (separately reported). Frozen section pathology reveals grade 2 adenocarcinoma consistent with a colon primary. A separate wedge resection of the right lower lobe nodule is performed also showing metastatic colon cancer.
For this procedure consider only the work of the additional wedge resection in the separate lobe. This is an add-on service.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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: There is no additional pre-service work

Description of Intra-Service Work: If there is more than one lung nodule present, then after the first wedge resection is performed and histopathologic diagnosis confirmed, wedge resection of the additional nodule(s) may be indicated. This entails performing the additional necessary wedge resection(s) in the same fashion as the initial wedge resection utilizing multiple firings of the tissue staplers ensuring clean margins. Some nodules may require electrocautery resection with suture closure of the lung parenchymal defect. Each of the resected nodules should be sent for histopathologic examination. The anesthetist is asked to inflate the operated lung and all resection sites are assessed for both hemostasis and air leakage. Additional suture reinforcement of staple (suture) lines is done as needed.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32506					
Sample Size:	300	**Resp N:**	42	**Response:** 14.0 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	20.00	100.00
Survey RVW:	1.25	3.50	**4.50**	7.00	17.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	15.00	**25.00**	40.00	90.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: ZZZ Global Code

CPT Code:	32506	**Recommended Physician Work RVU: 3.00**		
		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:	**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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32501	ZZZ	4.68	**RUC Time**

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	120,569

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	13,121

CPT Descriptor 2 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
44213	ZZZ	3.50	**RUC Time**

CPT Descriptor Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)

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:** 19.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32506**	**Key Reference CPT Code:** 32501	**Source of Time RUC Time**
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 Subsequent Observation Care 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	3.25	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.25
Urgency of medical decision making	3.25	3.38
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.13	3.38
Physical effort required	3.38	3.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.88	3.63
Outcome depends on the skill and judgment of physician	2.75	3.50
Estimated risk of malpractice suit with poor outcome	2.75	2.88

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.13	3.50
Intra-Service intensity/complexity	3.38	3.63
Post-Service intensity/complexity	3.00	3.13

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.*

A survey was conducted with 42 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 10 times for the surveyed code. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time was 25 minutes.

We are recommending a work RVU of 3.00 for this code. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32501, the expert panel felt 32506 took about the same amount of time and had less intensity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32500

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 863
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 705 Percentage 81.69 %

Specialty general surgery Frequency 85 Percentage 9.84 %

Specialty other Frequency 53 Percentage 6.14 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 438
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty cardiothoracic surgery Frequency 368 Percentage 84.01 %

Specialty general surgery Frequency 44 Percentage 10.04 %

Specialty other Frequency 16 Percentage 3.65 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33517

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32507 Tracking Number II7 Original Specialty Recommended RVU: **3.78**
Presented Recommended RVU: **3.78**
Global Period: ZZZ RUC Recommended RVU: **3.78**

CPT Descriptor: Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)
(Report 32507 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male smoker is found to have a growing left spiculated pulmonary nodule now measuring 3 cm in size. There is no evidence of metastatic disease. Pulmonary function is normal. Resection is indicated. The patient undergoes a diagnostic wedge resection to be followed by an appropriate more extensive resection (reported separately) based upon intraoperative pathology findings. This service represents only the additional services of the diagnostic wedge resection in a patient who goes on to have a more extensive lung resection procedure based upon the intraoperative pathology findings.
For this procedure consider only the work of the diagnostic wedge resection that is sent for intraoperative pathology. This is an add-on service

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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: There is no additional pre-service work

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing. The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. Abnormalities are noted. The worrisome lung nodule is located and its relationship to the pulmonary vasculature and bronchial tree assessed to determine that biopsy is feasible. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. The lung is mobilized as needed for assistance in exposing the nodule. Using multiple firings of tissue staplers a wedge resection of the nodule is performed removing the nodule with at least a 1- to 2 cm margin of normal lung parenchyma. As necessary, hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture.

Sterile portions of the resected nodule are saved for appropriate microbiologic testing if indicated. The remaining portions of resected lung are sent for frozen section evaluation to obtain a histopathologic diagnosis. If lung cancer is confirmed, then anatomic resection (eg, segmentectomy, lobectomy, pneumonectomy) (separately reported) may be indicated.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32507					
Sample Size:	300	**Resp N:**	43	**Response:** 14.3 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**10.00**	20.00	50.00
Survey RVW:	1.25	3.78	**4.72**	8.00	21.50
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	20.00	**30.00**	45.00	90.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: ZZZ Global Code

CPT Code:	32507	**Recommended Physician Work RVU: 3.78**		
		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:		**30.00**		

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32501	ZZZ	4.68	**RUC Time**

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	120,569

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	13,121

CPT Descriptor 2 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
44213	ZZZ	3.50	**RUC Time**

CPT Descriptor Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)

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:** 18.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 32507**	**Key Reference CPT Code:** 32501	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**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	3.25	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.25
Urgency of medical decision making	3.25	3.38
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.13	3.38
Physical effort required	3.25	3.38
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.88	3.63
Outcome depends on the skill and judgment of physician	3.13	3.63
Estimated risk of malpractice suit with poor outcome	2.75	3.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.00	3.25
Intra-Service intensity/complexity	3.25	3.63
Post-Service intensity/complexity	3.00	3.13

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.*

A survey was conducted with 43 respondents. 32501was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 10 times for the surveyed code. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time was 30 minutes.

We are recommending a work RVU of 3.78 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32501, the expert panel felt 32507 took slightly more time but was less intense.

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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was generally not previoulsy reported. It is estimated that if it was reported it was reported 15% of the time with code 32500 and 11% of the time with code 32095.

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1686
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1411 Percentage 83.68 %

Specialty general surgery Frequency 170 Percentage 10.08 %

Specialty other Frequency 106 Percentage 6.28 %

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.

Specialty cardiothoracic surgery Frequency 1004 Percentage 83.66 %

Specialty general surgery Frequency 120 Percentage 10.00 %

Specialty other Frequency 76 Percentage 6.33 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33517

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32601 Tracking Number II8 Original Specialty Recommended RVU: **5.50**
Presented Recommended RVU: **5.50**
Global Period: 000 RUC Recommended RVU: **5.50**

CPT Descriptor: Thoracoscopy, diagnostic, (separate procedure); lung, pericardial sac, mediastinal or pleural space, without biopsy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old man presents with a 4-week history of progressive shortness of breath. Chest x-ray shows blunting of the costophrenic angles on the right. Thoracentesis is nondiagnostic.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 100%

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 100%

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: On the day of surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar placement is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 to 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and each lung lobe. No abnormalities of the visceral and parietal

pleura and lung are noted and no biopsies are performed. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders for the operative day written. On the operative day, the procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays from the operative day are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32601					
Sample Size:	300	**Resp N:**	50	**Response:** 16.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	10.00	**15.00**	25.00	100.00
Survey RVW:	5.25	12.00	**14.00**	16.38	40.00
Pre-Service Evaluation Time:			**28.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	10.00	45.00	**60.00**	71.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **1.00** 99233x **1.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32601	**Recommended Physician Work RVU: 5.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**28.00**	**40.00**	**-12.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
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):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
31600	000	7.17	**RUC Time**

CPT Descriptor Tracheostomy, planned (separate procedure);

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52342	000	5.85	**RUC Time**	291

CPT Descriptor 1 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52276	000	4.99	**RUC Time**	11,919

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

Other Reference CPT Code	Global	Work RVU	Time Source
37182	000	16.97	**RUC Time**

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 13 **% of respondents:** 26.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32601**	**Key Reference CPT Code:** 31600	**Source of Time** **RUC Time**
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	60.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	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 Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**193.00**	**156.00**
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	3.62	2.08
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.77	2.46
Urgency of medical decision making	3.23	2.77
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.31	2.92
Physical effort required	2.54	2.46
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.15	2.77
Outcome depends on the skill and judgment of physician	3.23	2.69
Estimated risk of malpractice suit with poor outcome	2.77	2.85

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.46	2.38
Intra-Service intensity/complexity	3.62	2.54
Post-Service intensity/complexity	3.15	2.38

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.*

A survey was conducted and composed of 50 respondents. Code 31600 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 15 times for the surveyed code. Despite the 0 performance rate of the reference code, all thoracic surgeons are completely familiar with this procedure and have performed it many times in their careers. In 2009, the Key Reference Service was

performed 3,452 times by thoracic surgeons. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient.

Survey respondents indicated that two hospital visits were typically performed, which is not consistent with the global period. The expert panel recommended a single 99232 to represent the typical evaluation and management service performed on the evening of surgery within the global period. The panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: Reduced to 28 min. based on survey response
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning.
Scrub, dress, wait: No change.

The survey median intraservice time of 60 minutes and immediate post service time of 30 minutes are recommended.

We are recommending a work RVU of 5.50 for this code, which is the frequency weighted average of codes 32601, 32603, and 32605 which are being collapsed into this code. This value is below the 25th percentile of the survey, is selected solely to preserve budget neutrality and rank order in the proposal and is not representative of the physician work actually performed. The resulting IWPUT is 0.037, which is consistent with the inaccuracy of this recommendation, particularly compared to the reference code IWPUT of 0.114.

We recommend that this code be identified in the RUC database as valid for physician time and visit pattern only

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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) 32601, 32603, 32605

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 3238
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 2619 Percentage 80.88 %

Specialty general surgery Frequency 369 Percentage 11.39 %

Specialty other Frequency 251 Percentage 7.75 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,435
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization data for codes 32601 (2362), 32603 (27), and 32605 (46) was combined to get the total estimated frequency of 2435 procedrues that will be reproted with the code 32601 for Medicare.

Specialty cardiothoracic surgery Frequency 1969 Percentage 80.86 %

Specialty general surgery Frequency 277 Percentage 11.37 %

Specialty other Frequency 188 Percentage 7.72 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 32601

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32607 Tracking Number II9 Original Specialty Recommended RVU: **5.47**
Presented Recommended RVU: **5.47**
Global Period: 000 RUC Recommended RVU: **5.50**

CPT Descriptor: Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
(Do not report 32607 more than once per lung)
(Do not report 32607 in conjunction with, 32440, 32442, 32445, 32488, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 56-year-old male with worsening dyspnea and progressive bilateral diffuse infiltrates on CT scan. Transbronchialiopsies were nondiagnostic.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 100%

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 100%

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: On the day of surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the most representative areas of the lungs to biopsy. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 to 2) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural

fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum and each of the lung lobes. Abnormalities of the lung are noted. A diffuse infiltrative non-localized process involving the lung is seen. Both abnormal and normal regions of lung are identified and their relationship to the pulmonary vasculature and bronchial tree assessed to determine that biopsy is feasible. Using multiple firings of the endoscopic tissue staplers, at least 2 wedge resections of the lung are performed removing portions of both abnormal and normal lung. Each specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. As necessary hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture. Sterile portions of the resected lung are prepared and sent for appropriate microbiologic testing. The remaining portions of resected lung are sent for frozen section pathologic evaluation to ensure that adequate biopsy material has been obtained. If not, additional biopsies are taken. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The lung is again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders for the operative day written. On the operative day, the procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays from the operative day are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32607					
Sample Size:	300	**Resp N:**	50	**Response:** 16.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**6.00**	12.00	45.00
Survey RVW:	5.25	9.00	**12.50**	15.00	40.00
Pre-Service Evaluation Time:			**28.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32607	**Recommended Physician Work RVU: 5.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**28.00**	**40.00**	**-12.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**30.00**	
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):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
31600	000	7.17	**RUC Time**

CPT Descriptor Tracheostomy, planned (separate procedure);

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45380	000	4.43	**RUC Time**	799,816

CPT Descriptor 1 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52342	000	5.85	**RUC Time**	291

CPT Descriptor 2 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

Other Reference CPT Code	Global	Work RVU	Time Source
37182	000	16.97	**RUC Time**

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 20 **% of respondents:** 40.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32607**	**Key Reference CPT Code:** 31600	**Source of Time**
			RUC Time
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	45.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	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 Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**178.00**	**156.00**
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	3.35	1.95
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	2.30
Urgency of medical decision making	2.95	2.70
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.80	2.70
Physical effort required	2.70	2.45
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.90	2.75
Outcome depends on the skill and judgment of physician	3.20	2.65
Estimated risk of malpractice suit with poor outcome	2.75	2.70

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.25	2.30
Intra-Service intensity/complexity	2.90	2.45
Post-Service intensity/complexity	2.95	2.25

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.*

A survey was conducted with 51 respondents. Code 31600 was selected as the Key Reference Service, and was performed 3 times annually by the respondents, compared to 6 times for the surveyed code. The vignette was felt to be typical by 98% of the respondents, and the procedure was typically performed as an inpatient.

Survey respondents indicated that two hospital visits were typically performed, which is not consistent with the global period. The expert panel recommended a single 99232 to represent the typical evaluation and management service performed on the evening of surgery within the global period. The panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: Reduced to 28 min. based on survey response
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning.
Scrub, dress, wait: No change.

The survey median intraservice time of 45 minutes and the survey median immediate post service time of 30 minutes are 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) 32602 and 32657

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2909
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1559 Percentage 76.83 %

Specialty general surgery Frequency 285 Percentage 14.04 %

Specialty other Frequency 185 Percentage 9.11 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,183
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 9% of 32657 and 40% of 32602 current 2009 Medicare utilization

Specialty cardiothoracic surgery Frequency 1677 Percentage 76.82 %

Specialty general surgery Frequency 306 Percentage 14.01 %

Specialty other Frequency 200 Percentage 9.16 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32601

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32608 Tracking Number II10 Original Specialty Recommended RVU: **6.84**
Presented Recommended RVU: **6.84**
Global Period: 000 RUC Recommended RVU: **6.84**

CPT Descriptor: Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
(Do not report 32608 more than once per lung)
(Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 65-year-old male smoker presents with a growing pulmonary nodule, which is suspicious for lung cancer. Multiple other small nodules close to the surface within the same lung are seen on CT.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 100%

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 100%

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: On the day of surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the worrisome lung nodules. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 to 2) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary

are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum and each of the lung lobes. Abnormalities are noted. Nodularity of the visceral pleura and lung are noted. Biopsy of one of the lung nodules is accomplished by one of several techniques; core cutting needle biopsy, electrocautery excision, ultrasonic scalpel excision or stapled biopsy. Prior to removal from the chest cavity, the biopsied lung tissue is placed in a sterile bag in order to prevent trocar site contamination. As necessary hemostasis is secured with electrocautery and if needed the biopsy site is reinforced with sutures. If appropriate, sterile portions of the biopsied nodule are prepared and sent for appropriate microbiologic testing. The remaining portions of biopsied nodule are sent for frozen section evaluation to obtain a histopathologic diagnosis. Metastatic lung cancer is confirmed. Because of the extent of metastatic disease, the primary tumor is not resected. After completion of all necessary biopsies(s), the anesthetist is asked to inflate the operated lung and all biopsy sites are assessed for both hemostasis and air leakage. The lung is again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders for the operative day written. On the operative day, the procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays from the operative day are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32608					
Sample Size:	300	**Resp N:**	50	**Response:** 16.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	7.00	**12.00**	20.00	50.00
Survey RVW:	5.25	12.00	**14.00**	16.00	40.00
Pre-Service Evaluation Time:			**30.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	15.00	45.00	**60.00**	60.00	135.00

Immediate Post Service-Time:	**30.00**	
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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32608	**Recommended Physician Work RVU: 6.84**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**30.00**	**40.00**	**-10.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**60.00**		

Immediate Post Service-Time:	**30.00**	
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):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
31600	000	7.17	**RUC Time**

CPT Descriptor Tracheostomy, planned (separate procedure);

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52342	000	5.85	**RUC Time**	291

CPT Descriptor 1 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	000	6.74	**RUC Time**	33,522

CPT Descriptor 2 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

Other Reference CPT Code	Global	Work RVU	Time Source
37182	000	16.97	**RUC Time**

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 15 **% of respondents:** 30.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32608**	**Key Reference CPT Code:** 31600	**Source of Time** **RUC Time**
Median Pre-Service Time	65.00	50.00	
Median Intra-Service Time	60.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**195.00**	**156.00**
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	3.47	2.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	2.40
Urgency of medical decision making	3.27	2.73
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.13	2.67
Physical effort required	2.80	2.40
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.13	2.73
Outcome depends on the skill and judgment of physician	3.27	2.67
Estimated risk of malpractice suit with poor outcome	2.73	2.73

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.53	2.40
Intra-Service intensity/complexity	3.27	2.53
Post-Service intensity/complexity	3.20	2.27

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.*

A survey was conducted with 50 respondents. Code 31600 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 12 times for the surveyed code. Despite the 0

performance rate of the reference code, all thoracic surgeons are completely familiar with this procedure and have performed it many times in their careers. In 2009, the Key Reference Service was performed 3,452 times by thoracic surgeons. The vignette was felt to be typical by 98% of the respondents, and the procedure was typically performed as an inpatient.

Survey respondents indicated that two hospital visits were typically performed, which is not consistent with the global period. The expert panel recommended a single 99232 to represent the typical evaluation and management service performed on the evening of surgery within the global period. The panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: Reduced to 30 min. based on survey response
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 60 minutes which is the median time and the median immediate post service time of 30 minutes are 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) 32602 and 32657

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2909

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1558 Percentage 53.55 %

Specialty general surgery Frequency 285 Percentage 9.79 %

Specialty other Frequency 185 Percentage 6.35 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,183
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 9% of 32657 and 40% of 32602 current 2009 Medicare utilization

Specialty cardiothoracic surgery Frequency 1677 Percentage 76.82 %

Specialty general surgery Frequency 306 Percentage 14.01 %

Specialty other Frequency 200 Percentage 9.16 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32605

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32609 Tracking Number II11 Original Specialty Recommended RVU: **4.10**
Presented Recommended RVU: **4.58**
Global Period: 000 RUC Recommended RVU: **4.58**

CPT Descriptor: Thoracoscopy; with biopsy(ies) of pleura

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 68-year-old male pipe fitter presents with progressive dyspnea. A left pleural effusion is found along with generalized parietal pleural thickening. Pleural fluid cytology is nondiagnostic. Pleural biopsy is needed to establish diagnosis.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 100%

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 100%

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: On the day of surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the pleural abnormalities. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 to 2) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes

both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum and each of the lung lobes. Abnormalities of the visceral and parietal pleura are noted, and the worrisome portions of the pleura are identified and assessed for feasibility of biopsy. Using biopsy forceps or other thoracoscopic instrumentation pleural biopsies are performed removing at least 1- to 2 cm portions of pleura. Each specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. If appropriate, sterile portions of the resected pleura are prepared and sent for appropriate microbiologic testing. The remaining portions of resected pleura are sent for frozen section evaluation to ensure adequate tissue has been obtained, and if possible to obtain histopathologic diagnosis. After completion of all necessary biopsy(s)resection(s), the anesthetist is asked to inflate the operated lung assessing it for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders for the operative day written. On the operative day, the procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays from the operative day are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32609					
Sample Size:	300	**Resp N:**	50	**Response:** 16.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	7.00	**12.00**	20.00	50.00
Survey RVW:	4.95	9.00	**12.00**	14.94	40.00
Pre-Service Evaluation Time:			**28.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**20.00**		
Intra-Service Time:	10.00	30.00	**45.00**	60.00	120.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32609	**Recommended Physician Work RVU: 4.58**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**28.00**	**40.00**	**-12.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**45.00**		

Immediate Post Service-Time:	**30.00**	
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):	**40.00**	99231x **0.00** 99232x **1.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
31600	000	7.17	**RUC Time**

CPT Descriptor Tracheostomy, planned (separate procedure);

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
19103	000	3.69	**RUC Time**	107,851

CPT Descriptor 1 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
45380	000	4.43	**RUC Time**	799,816

CPT Descriptor 2 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

Other Reference CPT Code	Global	Work RVU	Time Source
37182	000	16.97	**RUC Time**

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 19 **% of respondents:** 38.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32609**	**Key Reference CPT Code:** 31600	**Source of Time** **RUC Time**
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	45.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	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 Subsequent Observation Care Time	0.0	0.00	

Median Total Time	**178.00**	**156.00**
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	3.47	2.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	2.40
Urgency of medical decision making	3.27	2.73
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.13	2.67
Physical effort required	2.80	2.40
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.13	2.73
Outcome depends on the skill and judgment of physician	3.27	2.67
Estimated risk of malpractice suit with poor outcome	2.73	2.73

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.53	2.40
Intra-Service intensity/complexity	3.27	2.53
Post-Service intensity/complexity	3.20	2.27

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.*

A survey was conducted with 51 respondents. Code 31600 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 12 times for the surveyed code. Despite the 0 performance rate of the reference code, all thoracic surgeons are completely familiar with this procedure and have performed it many times in their careers. In 2009, the Key Reference Service was performed 3,452 times

by thoracic surgeons. The vignette was felt to be typical by 98% of the respondents, and the procedure was typically performed as an inpatient.

Survey respondents indicated that two hospital visits were typically performed, which is not consistent with the global period. The expert panel recommended a single 99232 to represent the typical evaluation and management service performed on the evening of surgery within the global period. The panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: Reduced to 28 min. based on survey response
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 45 minutes which is the median time and the median immediate post service time of 30 minutes are 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) 32602

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 403
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 306 Percentage 75.93 %

Specialty general surgery Frequency 56 Percentage 13.89 %

Specialty other Frequency 41 Percentage 10.17 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 302
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization data for the current code 32602 is 3,390. Of this, it is estimated that 9% with be reported with 32609

Specialty cardiothoracic surgery Frequency 232 Percentage 76.82 %

Specialty general surgery Frequency 43 Percentage 14.23 %

Specialty other Frequency 27 Percentage 8.94 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33572

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32663 Tracking Number II16 Original Specialty Recommended RVU: **24.64**
Presented Recommended RVU: **24.64**
Global Period: 090 RUC Recommended RVU: **24.64**

CPT Descriptor: Thoracoscopy, surgical; with lobectomy, total or segmental (eg, single lobe)
(For thoracoscopic (VATS) segmentectomy see 3266X4)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old former smoker presents with a 2 cm adenocarcinoma located peripherally in the left lower lobe. The staging workup shows no evidence of metastatic disease. The patients pulmonary function is such he would tolerate lobectomy.

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 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the lung cancer. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (3 or 4) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the

lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The lung cancer present in the lower lobe is identified. The lung is retracted superiorly to expose the diaphragmatic surface. The inferior pulmonary ligament is divided with electrocautery, and the mediastinal pleura dissected away from the inferior pulmonary vein anteriorly and posteriorly. A right angle clamp is used to carefully dissect around the inferior pulmonary vein away from the superior pulmonary vein to the upper lobe., The endoscopic vascular stapler is passed across the inferior pulmonary vein and fired to divide it. The lower lobe is retracted inferiorly and dissection in the fissure to separate the upper and lower lobes performed. At the base of the fissure the pulmonary artery is identified and carefully dissected free. The dissection is continued until the branches to the lingula,, superior segment and the four basilar segments are identified. The arterial branches to the lower lobe are divided using the endoscopic vascular stapler. Underneath the artery the lower lobe bronchus is identified, isolated, and divided using the endoscopic tissue stapler taking care not to narrow the middle lobe bronchus. Using multiple firings of the endoscopic tissue stapler the fissures between the lower lobe and upper lobe is completely divided. The resected lower lobe is endoscopically placed in a sterile bag which is closed and then removed from the chest cavity through the accessory incision. The specimen is sent to pathology for frozen section analysis of the margin which can require 15 to 20 minutes. For lung cancer, a thoracoscopic mediastinal and regional lymphadenectomy may be performed (separately reported). Once confirmation is obtained indicating that no further surgery is required (e.g. benign lesion or margins negative if malignant) the steps for closure are begun. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. The anesthetist is again asked to inflate the operated lung and with the thoracoscope still in place observing that the remaining lung completely re-expands. The thoracoscope is then removed. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure’s outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32663					
Sample Size:	300	**Resp N:**	55	**Response:** 18.3 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	**20.00**	30.00	200.00
Survey RVW:	25.00	27.23	**31.00**	36.98	45.88
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	143.00	**155.00**	180.00	360.00

Immediate Post Service-Time:	**30.00**	
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):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32663	**Recommended Physician Work RVU: 24.64**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**155.00**		

Immediate Post Service-Time:	**30.00**	
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):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32484	090	25.38	**RUC Time**

CPT Descriptor Removal of lung, other than total pneumonectomy; single segment (segmentectomy)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34802	090	23.79	**RUC Time**	13,847

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44204	090	26.42	**RUC Time**	10,969

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

Other Reference CPT Code	Global	Work RVU	Time Source
32486	090	42.88	**RUC Time**

CPT Descriptor Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)

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:** 34.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 32663**	**Key Reference CPT Code:** 32484	**Source of Time** **RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	155.00	139.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	170.0	210.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**507.00**	**561.00**	

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	3.74	3.58
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.74	3.47
Urgency of medical decision making	3.00	2.95
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.21	3.74
Physical effort required	3.63	3.42
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.37	3.21
Outcome depends on the skill and judgment of physician	4.05	3.74
Estimated risk of malpractice suit with poor outcome	2.58	2.47

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.63	3.47
Intra-Service intensity/complexity	4.05	3.84
Post-Service intensity/complexity	3.26	2.95

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.*

A survey was conducted with 56 respondents. Code 32484 was selected as the Key Reference Service, and was performed 4 times annually by the respondents, compared to 20 times for the surveyed code. The vignette was felt to be typical by 95% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 155 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

Recommending to maintain the current work value of 24.64. This code was valued in the 3rd 5 year review only for thoracoscopic lobectomy because it was the predominant procedure performed at that time. The survey supports this recommendation.

The IWPUT of 32663 is 0.088 compared to the IWPUT of 0.089 for the key reference code 32484, removal of lung, other than total pneumonectomy; single segment (segmentectomy). Compared to the key reference code, the expert panel felt that 32663 was appropriately valued with longer intraoperative time and higher work intensity as reflected by the IWPUT.

Historically thoracoscopic lobectomy and segmentectomy have been grouped together. From 1993 to 2005 segmentectomies were not performed thoracoscopically. The bundling of these two procedures did not matter until the past few years. As evidenced by the current RUC valuations for the open segmentectomy and lobectomy, the work involved is slightly different. In order to capture the precision of the open codes, we decided to separate VATS lobectomy and segmentectomy to accurately reflect the work involved.
The current code 32663 was recently valued in 2005 in the work review and the expert panel felt that the current value is accurate. The survey respondents delivered results suggesting that the relative value for segmentectomy was slightly lower than that for lobectomy (median of 29 versus 31 RVUs). The Expert panel felt that the new median values were to high with regard to their absolute values but appropriate with regard to their relativity. The Expert Panel felt that the valuation for 32663 at 24.64 for the lobectomy was correct and proposes that the valuation for segmentectomy be set utilizing the ratio of the 25th percentile values (26.00 and 27.23) proposed by the survey respondents. This results in the recommendation of 23.53 for the segmentectomy which results in a net savings for these codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32663

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 5313
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 4533 Percentage 85.31 %

Specialty general surgery Frequency 524 Percentage 9.86 %

Specialty other Frequency 256 Percentage 4.81 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,995
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the existing code 32663 is 4342. It is estimated that of this number, 8% of the procedures (347) will be reported with code 32669 and 92% of the procedrues (3995) will be reproted with code 32663.

Specialty cardiothoracic surgery Frequency 3409 Percentage 85.33 %

Specialty general surgery Frequency 394 Percentage 9.86 %

Specialty other Frequency 192 Percentage 4.80 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 32663

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32666 Tracking Number II12 Original Specialty Recommended RVU: **14.50**
Presented Recommended RVU: **14.50**
Global Period: 090 RUC Recommended RVU: **14.50**

CPT Descriptor: Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral
(To report bilateral procedure, report 32666 with modifier 50)
(Do not report 32666, in conjunction with 32440, 32442, 32445, 32488, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 68-year-old female two years status post right leg resection for osteosarcoma presents with a new solitary pulmonary nodule in the right upper lobe, There is no evidence of local recurrence. Metastatic disease is suspected. The patient is referred for curative resection.

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 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the abnormal lung nodule. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord, etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1or 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary

are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The worrisome lung nodule is identified, and its relationship to the pulmonary vasculature and bronchial tree assessed to determine that biopsy is feasible. The lung is mobilized as needed for assistance in exposing the nodule. Using multiple firings of endoscopic tissue staplers a wedge resection of the nodule is performed removing the nodule with at least a 1- to 2 cm free margin of normal lung parenchyma. The specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. As necessary hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture. If necessary, sterile portions of the resected nodule are prepared and sent for appropriate microbiologic testing. The remaining portions of resected lung are sent for frozen section evaluation to obtain a histopathologic diagnosis and ensure that the nodule has been removed with free margins. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress, and when ready the patient is discharged. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32666					
Sample Size:	300	**Resp N:**	55	**Response:** 18.3 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	15.00	**25.00**	45.00	100.00
Survey RVW:	11.00	14.50	**19.00**	24.06	40.00
Pre-Service Evaluation Time:			**50.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	40.00	60.00	**75.00**	90.00	210.00

Immediate Post Service-Time:	**30.00**	
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):	**60.00**	99231x **1.00** 99232x **0.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32666	**Recommended Physician Work RVU: 14.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**75.00**		

Immediate Post Service-Time:	**30.00**	
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):	**60.00**	99231x **1.00** 99232x **0.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32662	090	14.99	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36830	090	12.03	**RUC Time**	27,436

CPT Descriptor 1 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22554	090	17.69	**RUC Time**	32,339

CPT Descriptor 2 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

Other Reference CPT Code	Global	Work RVU	Time Source
32651	090	18.78	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with partial pulmonary decortication

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 17 **% of respondents:** 30.9 **%**

TIME ESTIMATES (Median)	**CPT Code: 32666**	**Key Reference CPT Code:** 32662	**Source of Time** **RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	75.00	98.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**317.00**	**350.00**	

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	3.35	3.18
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.35
Urgency of medical decision making	2.94	2.82
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.24	3.12
Physical effort required	3.41	3.06
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.88	3.18
Outcome depends on the skill and judgment of physician	3.29	3.41
Estimated risk of malpractice suit with poor outcome	2.59	2.65

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.12	3.35
Intra-Service intensity/complexity	3.12	3.29
Post-Service intensity/complexity	2.71	2.71

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.*

A survey was conducted with 55 respondents. Code 32662 was selected as the Key Reference Service, and was performed 8 times annually by the respondents, compared to 25 times for the surveyed code. The vignette was felt to be typical by 95% of the respondents, and the procedure was typically performed as an inpatient.

An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 75 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 3 days as supported by the survey. The expert panel assigned a typical hospital visit pattern consistent with the other thoracoscopic lung resection codes and a discharge day, supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 14.50 for this code, which is the 25th percentile of the survey values. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family and includes an appropriate relationship to the comparable open code.

The IWPUT of 32666 is 0.093 is comparable to the IWPUT of 0.083 for the key reference code 32662, thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass. It is also comparable with the IWPUT of the other thoracoscopic pulmonary resection code 32663 0.105

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) 32657

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 8734
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 7861 Percentage 90.00 %

Specialty general surgery Frequency 698 Percentage 7.99 %

Specialty other Frequency 175 Percentage 2.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,551
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The total utilization of the current code 32657 for 2009 is 9029. Of this 72% will go to 32666.

Specialty cardiothoracic surgery Frequency 5241 Percentage 80.00 %

Specialty general surgery Frequency 937 Percentage 14.30 %

Specialty other Frequency 373 Percentage 5.69 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32662

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32667 Tracking Number II13 Original Specialty Recommended RVU: **3.81**
Presented Recommended RVU: **3.81**
Global Period: ZZZ RUC Recommended RVU: **3.00**

CPT Descriptor: Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in additionto code for primary procedure)
(Report 32667 only in conjunction with 32666)
(Do not report 32667 in conjunction with 32440, 32442, 32445, 32488, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female two years status post right leg resection for osteosarcoma presents with a nodule in the right upper lobe and an additional nodule in the right lower lobe. There is no evidence of local recurrence and patient is referred for curative resections
The patient has a thoracoscopic wedge resection of the right upper lobe nodule (separately reported). A separate wedge resection of the right lower lobe nodule is performed
For this procedure consider only the work of the additional wedge resection in the separate lobe. This is an add-on service.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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: There is no additional pre-service work

Description of Intra-Service Work: If there is more than one lung nodule present, then after the first wedge resection is performed and histopathologic diagnosis confirmed, wedge resection of the additional nodule(s) may be indicated. This entails performing the additional necessary wedge resection(s) in the same fashion as the initial wedge resection utilizing multiple firings of the endoscopic tissue staplers. Some nodules may require electrocautery resection with suture closure of the lung parenchymal defect. All nodules should be removed with ideally 1- to 2 cm free margin. Each specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. Each of the resected nodules should be sent for histopathologic examination. The anesthetist is asked to inflate the operated lung and all resection sites are assessed for both hemostasis and air leakage.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32667					
Sample Size:	300	**Resp N:**	44	**Response:** 14.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	8.00	**10.00**	22.00	50.00
Survey RVW:	1.25	3.81	**4.59**	7.98	20.00
Pre-Service Evaluation Time:			**8.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	20.00	**25.00**	35.00	90.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: ZZZ Global Code

CPT Code:	32667	**Recommended Physician Work RVU: 3.00**		
		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:	**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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32501	ZZZ	4.68	**RUC Time**

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	120,569

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	13,121

CPT Descriptor 2 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
44213	ZZZ	3.50	**RUC Time**

CPT Descriptor Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)

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:** 20.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 32667**	**Key Reference CPT Code:** 32501	**Source of Time** RUC Time
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 Subsequent Observation Care 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	3.22	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	3.22
Urgency of medical decision making	3.22	3.33
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.33	3.56
Physical effort required	3.22	3.22
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.11	3.67
Outcome depends on the skill and judgment of physician	3.22	3.67
Estimated risk of malpractice suit with poor outcome	2.67	2.89

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.11	3.22
Intra-Service intensity/complexity	3.33	3.78
Post-Service intensity/complexity	2.89	3.11

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.*

A survey was conducted with 44 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 10 times for the surveyed code. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time 25 minutes.

Compared to the key reference code 32501, the expert panel felt 32667 took the same amount of time but had less intense intraoperative work.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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.

FREQUENCY INFORMATION

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

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

Specialty cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 873
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 699 Percentage 80.06 %

Specialty general surgery Frequency 125 Percentage 14.31 %

Specialty other Frequency 49 Percentage 5.61 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 655
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. the utilization estimate is new RVUs not currently reported

Specialty cardiothoracic surgery Frequency 524 Percentage 80.00 %

Specialty general surgery Frequency 94 Percentage 14.35 %

Specialty other Frequency 37 Percentage 5.64 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33517

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32668 Tracking Number II14 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: ZZZ RUC Recommended RVU: **4.00**

CPT Descriptor: Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)
(Report 32668 in conjunction with 32440, 32442, 33245, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32669, 32663, 32670, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 yo male smoker is found to have a growing left spiculated pulmonary nodule now measuring 3 cm in size. There is no evidence of metastatic disease. Pulmonary function is normal. Resection is indicated.
The patient undergoes a thoracoscopic diagnostic wedge resection to be followed by an appropriate more extensive resection (reported separately) based upon intraoperative pathology findings. This service represents only the additional services of the thoracoscopic diagnostic wedge resection in a patient who goes on to have a more extensive lung resection procedure based upon the pathology findings.
For this procedure consider only the work of the thoracoscopic diagnostic wedge resection that is sent for intraoperative pathology. This is an add-on service.

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 100% , 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: There is no additional pre-service work.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1or 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The worrisome lung nodule is located and its relationship to the pulmonary vasculature and bronchial tree assessed to determine

that resection is feasible. The lung is mobilized as needed for assistance in exposing the nodule. Using multiple firings of endoscopic tissue staplers a wedge resection of the nodule is performed removing the nodule with at least a 1- to 2 cm margin of normal lung parenchyma. The specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. As necessary hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture. If necessary, sterile portions of the resected nodule are prepared and sent for appropriate microbiologic testing. The remaining portions of resected lung are sent for frozen section evaluation to obtain a histopathologic diagnosis. If lung cancer is confirmed, then anatomic resection (eg, VATS or open segmentectomy, lobectomy, pneumonectomy) (separately reported) may be indicated.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32668					
Sample Size:	300	**Resp N:**	44	**Response:** 14.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	8.00	**20.00**	25.00	200.00
Survey RVW:	1.25	4.00	**5.25**	8.75	23.00
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	20.00	**30.00**	45.00	90.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: ZZZ Global Code

CPT Code:	32668	**Recommended Physician Work RVU: 4.00**		
		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:		**30.00**		

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32501	ZZZ	4.68	**RUC Time**

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
63048	ZZZ	3.47	**RUC Time**	120,569

CPT Descriptor 1 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	13,121

CPT Descriptor 2 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
44213	ZZZ	3.50	**RUC Time**

CPT Descriptor Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 **% of respondents:** 22.7 **%**

TIME ESTIMATES (Median)	**CPT Code: 32668**	**Key Reference CPT Code:** 32501	**Source of Time RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**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	3.40	3.10
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	3.10
Urgency of medical decision making	3.30	3.40
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.60
Physical effort required	3.20	3.20
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.20	3.60
Outcome depends on the skill and judgment of physician	3.30	3.60
Estimated risk of malpractice suit with poor outcome	2.80	2.80

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.10	3.20
Intra-Service intensity/complexity	3.40	3.70
Post-Service intensity/complexity	2.90	2.80

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.*

A survey was conducted with 44 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 20 times for the surveyed code. The vignette was felt to be typical by 95% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time 30 minutes.

We are recommending a work RVU of 4.00 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32501, the expert panel felt 32668 took slightly longer and had less intensity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32602 and 32657

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

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. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1283 Percentage 80.18 %

Specialty general surgery Frequency 224 Percentage 14.00 %

Specialty other Frequency 93 Percentage 5.81 %

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. It is estimated that 5% of the open and thoracoscopic lobectomies are preceeded by a diagnostic thoracoscopic wedge resection.

Specialty cardiothoracic surgery Frequency 960 Percentage 80.00 %

Specialty general surgery Frequency 168 Percentage 14.00 %

Specialty other Frequency 72 Percentage 6.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 33572

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32669 Tracking Number II15 Original Specialty Recommended RVU: **23.53**
Presented Recommended RVU: **23.53**
Global Period: 090 RUC Recommended RVU: **23.53**

CPT Descriptor: Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78-year-old male smoker with severe emphysema present with nonsmall cell lung cancer limited to the superior segment of the left lower lobe. Patient is felt not to be a candidate for lobectomy and segmental resection is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the lung cancer. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (3 or 4) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest

and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The cancer in the superior segment of the lower lobe is identified. The lung is retracted superiorly to expose the diaphragmatic surface. The inferior pulmonary ligament is divided with electrocautery, and the mediastinal pleura dissected away from the inferior pulmonary vein anteriorly and posteriorly. A right angle clamp is used to carefully dissect around the inferior pulmonary vein avoiding the superior pulmonary vein, The superior segmental vein branch of the inferior pulmonary vein is identified and separately isolated. The endoscopic vascular stapler is passed across the superior segmental vein and fired to divide it. The lower lobe is retracted inferiorly and dissection in the fissure to separate the upper and lower lobes performed. At the base of the fissure the pulmonary artery is identified and carefully dissected free. The dissection is continued until the branches to the superior segment of the lower lobe and the four basilar segments are identified. The arterial branch(s) to the superior segment is divided using the endoscopic vascular stapler. Underneath the artery the superior segmental bronchus to the lower lobe is identified, isolated, and divided using the endoscopic tissue stapler taking care not to narrow the basilar segmental bronchi. Using multiple firings of the endoscopic tissue stapler the fissures between the superior segment of the lower lobe and the upper lobe, and superior segment and the basilar segments are divided. The resected superior segment is endoscopically placed in a sterile bag which is closed and then removed from the chest cavity through the accessory incision. The specimen is sent to pathology for frozen section analysis of the margin which can require 15 to 20 minutes. For lung cancer, a thoracoscopic mediastinal and regional lymphadenectomy is performed (separately reported). Once confirmation is obtained indicating that no further surgery is required (e.g. benign lesion or margins negative if malignant) the steps for closure are begun. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. The anesthetist is again asked to inflate the operated lung and with the thoracoscope still in place observing that the remaining lung completely re-expands. The thoracoscope is then removed. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32669					
Sample Size:	300	**Resp N:**	54	**Response:** 18.0 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	8.00	50.00
Survey RVW:	17.62	26.00	**29.00**	35.00	44.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	120.00	**150.00**	180.00	255.00

Immediate Post Service-Time:	**30.00**	
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):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32669	**Recommended Physician Work RVU: 25.53**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**150.00**		

Immediate Post Service-Time:	**30.00**	
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):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32484	090	25.38	**RUC Time**

CPT Descriptor Removal of lung, other than total pneumonectomy; single segment (segmentectomy)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34802	090	27.39	**RUC Time**	13,487

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44204	090	26.42	**RUC Time**	10,969

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

Other Reference CPT Code	Global	Work RVU	Time Source
44207	090	31.92	**RUC Time**

CPT Descriptor Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)

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:** 50.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32669**	**Key Reference CPT Code:** 32484	**Source of Time** **RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	150.00	139.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	170.0	210.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**502.00**	**561.00**	

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	3.56	3.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.63
Urgency of medical decision making	2.81	2.89
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.04	3.81
Physical effort required	3.56	3.52
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.33	3.33
Outcome depends on the skill and judgment of physician	3.74	3.78
Estimated risk of malpractice suit with poor outcome	2.74	2.89

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.56	3.67
Intra-Service intensity/complexity	4.19	3.96
Post-Service intensity/complexity	3.15	3.19

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.*

A survey was conducted with 54 respondents. Code 32484 was selected as the Key Reference Service, and was performed 4 times annually by the respondents, compared to 8 times for the surveyed code. The vignette was felt to be typical by 96% of the respondents, and the procedure was typically performed as an inpatient.

An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 150 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

In order to achieve budget neutrality we applied the ratio of the expert panel recommendations (26 for thoracoscopic segmentectomy and 27.23 for thoracoscopic lobectomy) to the current and recommended value of 24.64 for the thoracoscopic lobectomy. This resulted in our recommended value for thoracosocpic segmentectomy of 23.53.

The IWPUT of 32669 is 0.084 compared to the IWPUT of 0.089 for the key reference code 32484, removal of lung, other than total pneumonectomy; single segment (segmentectomy). Compared to the key reference code, the expert panel felt that 32669 was appropriately valued with longer intraoperative time.

Historically thoracoscopic lobectomy and segmentectomy have been grouped together. From 1993 to 2005 segmentectomies were not performed thoracoscopically. The bundling of these two procedures did not matter until the past few years. As evidenced by the current RUC valuations for the open segmentectomy and lobectomy, the work involved is slightly different. In order to capture the precision of the open codes, we decided to separate VATS lobectomy and segmentectomy to accurately reflect the work involved.
The current code 32663 was recently valued in 2005 in the work review and the expert panel felt that the current value is accurate. The survey respondents delivered results suggesting that the relative value for segmentectomy was slightly lower than that for lobectomy (median of 29 versus 31 RVUs). The Expert panel felt that the new median values were to high with regard to their absolute values but appropriate with regard to their relativity. The Expert Panel felt that the valuation for 32663 at 24.64 for the lobectomy was correct and proposes that the valuation for segmentectomy be set utilizing the ratio of the 25th percentile values (26.00 and 27.23) proposed by the survey respondents. This results in the recommendation of 23.53 for the segmentectomy which results in a net savings for these codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

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

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32663

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 462
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 394 Percentage 85.28 %

Specialty general surgery Frequency 46 Percentage 9.95 %

Specialty other Frequency 22 Percentage 4.76 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 347
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the existing code 32663 is 4342. It is estimated that of this number, 8% of the procedures (347) will be reported with code 32669 and 92% of the procedrues (3995) will be reproted with code 32663.

Specialty cardiothoracic surgery Frequency 296 Percentage 85.30 %

Specialty general surgery Frequency 34 Percentage 9.79 %

Specialty other Frequency 17 Percentage 4.89 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32663

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32670 Tracking Number II17 Original Specialty Recommended RVU: **29.75**
Presented Recommended RVU: **29.75**
Global Period: 090 RUC Recommended RVU: **28.52**

CPT Descriptor: Thoracoscopy, surgical; with removal of two lobes (bilobectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 69-year-old male presents with centrally located nonsmall cell lung cancer which involves both the middle and lower lobe orifices. Bilobar resection (combined resection of middle and lower lobes) is required.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the lung cancer. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial right trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (3 or 4) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest

and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The central lung cancer is identified. The lung is retracted superiorly to expose the diaphragmatic surface. The inferior pulmonary ligament is divided with electrocautery, and the mediastinal pleura dissected away from the inferior pulmonary vein anteriorly and posteriorly. A right angle clamp is used to carefully dissect around the inferior pulmonary vein away from the superior pulmonary vein to the upper lobe, The endoscopic vascular stapler is passed across the inferior pulmonary vein and fired to divide it. In a similar fashion the middle lobe vein is dissected free and isolated from the superior pulmonary vein. It too is divided utilizing the endoscopic vascular stapler. The lower lobe is retracted inferiorly and dissection in the fissure to separate the upper and lower lobes performed. At the base of the fissure the pulmonary artery is identified and carefully dissected free. The dissection is continued until the branches to the middle lobe, superior segment and the four basilar segments are identified. The arterial branches are divided using the endoscopic vascular stapler. Underneath the artery the bronchus intermedius is identified, isolated, and divided using the endoscopic tissue stapler taking care not to narrow the upper lobe bronchus. Using multiple firings of the endoscopic tissue stapler the fissures between the lower lobe and upper lobe, and upper lobe and middle lobe are divided. The resected middle and lower lobes are endoscopically placed in a sterile bag which is closed and then removed from the chest cavity through the accessory incision. The specimen is sent to pathology for frozen section analysis of the margin which can require 15 to 20 minutes. For lung cancer, a thoracoscopic mediastinal and regional lymphadenectomy may be performed (separately reported). Once confirmation is obtained indicating that no further surgery is required (e.g. benign lesion or margins negative if malignant) the steps for closure are begun. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. The anesthetist is again asked to inflate the operated lung and with the thoracoscope still in place observing that the remaining lung completely re-expands. The thoracoscope is then removed. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32670					
Sample Size:	300	**Resp N:**	55	**Response:** 18.3 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**2.00**	5.00	15.00
Survey RVW:	23.00	29.75	**35.00**	40.75	60.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	150.00	**180.00**	205.00	360.00

Immediate Post Service-Time:	**30.00**	
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):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32670	**Recommended Physician Work RVU: 28.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
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):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32486	090	42.88	**RUC Time**

CPT Descriptor Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34802	090	23.79	**RUC Time**	13,487

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44204	090	26.42	**RUC Time**	10,969

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

Other Reference CPT Code	Global	Work RVU	Time Source
32484	090	25.38	**RUC Time**

CPT Descriptor Removal of lung, other than total pneumonectomy; single segment (segmentectomy)

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:** 40.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32670**	**Key Reference CPT Code:** 32486	**Source of Time RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	180.00	240.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	170.0	360.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**532.00**	**812.00**	

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	3.82	3.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.91	3.95
Urgency of medical decision making	3.41	3.32
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.45	4.36
Physical effort required	3.91	3.77
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	4.41	4.32
Estimated risk of malpractice suit with poor outcome	3.45	3.27

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.86	3.77
Intra-Service intensity/complexity	4.27	4.27
Post-Service intensity/complexity	3.77	3.77

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.*

A survey was conducted with 55 respondents. Code 32486 was selected as the Key Reference Service, and was performed 3 times annually by the respondents, compared to 2 times for the surveyed code. The vignette was felt to be typical by 89% of the respondents, and the procedure was typically performed as an inpatient.

An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 180 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

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) 32482

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Rarely

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 391
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 3343 Percentage 854.98 %

Specialty general surgery Frequency 39 Percentage 9.97 %

Specialty other Frequency 19 Percentage 4.85 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 294
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilizaation for the open code 32482 is 890. It is estimated that 1/3 of these procedures (294) will be reported using the new code 32670.

Specialty cardiothoracic surgery Frequency 251 Percentage 85.37 %

Specialty general surgery Frequency 29 Percentage 9.86 %

Specialty other Frequency 14 Percentage 4.76 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32652

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32671 Tracking Number II18 Original Specialty Recommended RVU: **31.92**
Presented Recommended RVU: **31.92**
Global Period: 090 RUC Recommended RVU: **31.92**

CPT Descriptor: Thoracoscopy, surgical; with removal of lung (pneumonectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 64-year-old female presents with a squamous carcinoma of the left upper lobe involving the left mainstem bronchus requiring pneumonectomy for complete excision.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the lung cancer. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (3 or 4) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent if appropriate for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral

pleura, diaphragm, mediastinum, and lung. Abnormalities of the visceral and parietal pleura and lung are noted. Retract lung superiorly to expose the diaphragmatic surface. The inferior pulmonary ligament is divided with electrocautery, and the mediastinal pleura dissected away from the inferior pulmonary vein anteriorly and posteriorly. A right angle clamp is used to carefully dissect around the inferior pulmonary vein away from the superior pulmonary vein, The endoscopic vascular stapler is passed across the inferior pulmonary vein and fired to divide it. A right angle clamp is used to carefully dissect around the superior pulmonary vein, and the endoscopic vascular stapler is passed across the superior pulmonary vein and fired to divide it. The lung is retracted inferiorly and posteriorly and the pulmonary artery identified and carefully dissected free. The pulmonary artery is encircled with a vascular loop. The pulmonary artery is divided with the endoscopic vascular stapler. The mainstem bronchus is dissected free. For lung cancer, a thoracoscopic mediastinal and regional lymphadenectomy is performed (separately reported). The mainstem bronchus is then divided with the endoscopic tissue stapler. The resected lung is endoscopically placed in a sterile bag which is closed and then removed from the chest cavity through the accessory incision. The specimen is sent to pathology for frozen section analysis of the margin which can require 15 to 20 minutes. Once confirmation is obtained indicating that no further surgery is required (e.g. benign lesion or margins negative if malignant) the steps for closure are begun. The anesthetist is asked to inflate the operated side and the bronchial staple line is assessed for air leakage. All vascular staple lines are assessed for hemostasis. The chest cavity is irrigated with several liters of saline. A chest tube(s) is inserted through a separate interspace incision(s) to provide for stabilization of the mediastinum. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch. With the patient supine and positive pressure from the anesthetist the chest tube is removed and pursestring skin suture tied.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. These patients are usually in an ICU on the first postoperative day. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress,. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32671					
Sample Size:	300	**Resp N:**	55	**Response:** 18.3 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**0.00**	1.00	12.00
Survey RVW:	27.00	31.92	**38.00**	44.77	63.04
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	140.00	**180.00**	180.00	360.00

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32671	**Recommended Physician Work RVU: 31.92**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**180.00**		

Immediate Post Service-Time:	**30.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**70.00**	99291x **1.00** 99292x **0.00**
Other Hospital time/visit(s):	**170.00**	99231x **1.00** 99232x **1.00** 99233x **2.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32486	090	42.88	**RUC Time**

CPT Descriptor Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
61510	090	30.83	**RUC Time**	6,697

CPT Descriptor 1 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35646	090	32.98	**RUC Time**	2,387

CPT Descriptor 2 Bypass graft, with other than vein; aortobifemoral

Other Reference CPT Code	Global	Work RVU	Time Source
32652	090	29.13	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis

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:** 40.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 32671**	**Key Reference CPT Code:** 32486	**Source of Time RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	180.00	240.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	70.0	0.00	
Median Other Hospital Visit Time	170.0	360.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**602.00**	**812.00**	

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	4.10	3.62
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.24	3.95
Urgency of medical decision making	3.62	3.29
Technical Skill/Physical Effort (Mean)		
Technical skill required	4.33	4.29
Physical effort required	4.10	3.81
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	4.52	3.95
Outcome depends on the skill and judgment of physician	4.43	4.10
Estimated risk of malpractice suit with poor outcome	3.43	3.10

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	4.33	3.99
Intra-Service intensity/complexity	4.48	4.29
Post-Service intensity/complexity	4.29	3.86

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.*

A survey was conducted with 55 respondents. Code 32486 was selected as the Key Reference Service, and was performed 2 times annually by the respondents, compared to 0 times for the surveyed code. The vignette was felt to be typical by 85% of the respondents, and the procedure was typically performed as an inpatient.

An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 180 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 6 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 31.92 for this code, which is the 25th percentile of the survey values. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

The IWPUT of 32671 is 0.092 compared to the IWPUT of 0.102 for the key reference code 32486, removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy). Compared to the key reference code, the expert panel felt that 32671 was appropriately valued with shorter intraoperative time and less work intensity as reflected by the IWPUT.

Separate SORs have been provided for the 0 performance rate to show the aggregate data, the data for those with experience only and the data for those with no experience. The reference code for aggregate data is 32486, the reference code for those with no experience is also 32486, the reference code for those with experience is 32422.

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) 32999 or 32440

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Rarely

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 27
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 23 Percentage 85.18 %

Specialty general surgery Frequency 2 Percentage 7.40 %

Specialty other Frequency 2 Percentage 7.40 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2% of current 2009 Medicare utilization of 32440.

Specialty cardiothoracic surgery Frequency 17 Percentage 85.00 %

Specialty general surgery Frequency 2 Percentage 10.00 %

Specialty other Frequency 1 Percentage 5.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32503

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32672 Tracking Number II19 Original Specialty Recommended RVU: **27.00**
Presented Recommended RVU: **27.00**
Global Period: 090 RUC Recommended RVU: **27.00**

CPT Descriptor: Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 45-year-old woman with severe COPD and dyspnea presents for LVRS. She has upper lobe predominant emphysema and is an appropriate candidate for LVRS

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 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the emphysematous lung. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (2 or 3) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are carefully freed so as not to injure the severely emphysematous lung. Pleural fluid if present and if

appropriate is sent if appropriate for cytology and microbiology. The chest and lung are explored. The target areas of severe emphysematous lung are noted and using many applications of the endoscopic stapling device with specially applied buttressing material a significant portion of emphysematous lung is removed. Typically about two-thirds of the affected lobe is removed. On the ipsilateral side, other areas of destroyed lung may be removed as well from the other lobe(s) (not separately reported). The specimens are removed from the chest in a sterile bag and sent to pathology. The staple lines are reinforced as necessary with additional staple applications, suturing, or by the application of tissue sealants. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. A pleural tent or pleurodesis is done if needed. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. The anesthetist is again asked to inflate the operated lung and with the thoracoscope still in place observing that the remaining lung completely re-expands. The thoracoscope is then removed. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress, and when ready the patient is discharged. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for on-going outpatient pulmonary rehabilitation and additional follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32672					
Sample Size:	300	**Resp N:**	54	**Response:** 18.0 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**3.00**	5.00	20.00
Survey RVW:	14.99	27.00	**28.00**	32.83	64.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**18.00**		
Intra-Service Time:	45.00	90.00	**120.00**	120.00	240.00

Immediate Post Service-Time:	**30.00**	
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):	**265.00**	99231x **1.00** 99232x **2.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32672	**Recommended Physician Work RVU: 27.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
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):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**265.00**	99231x **1.00** 99232x **2.00** 99233x **3.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
32141	090	27.18	**RUC Time**

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34802	090	23.79	**RUC Time**	13,487

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44204	090	26.42	**RUC Time**	10,969

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

Other Reference CPT Code	Global	Work RVU	Time Source
32652	090	29.13	**RUC Time**

CPT Descriptor Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis

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:** 51.8 **%**

TIME ESTIMATES (Median)	**CPT Code: 32672**	**Key Reference CPT Code:** 32141	**Source of Time RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	120.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	265.0	345.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**567.00**	**673.00**	
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	3.43	3.36
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.64
Urgency of medical decision making	2.39	2.46
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.39	3.25
Physical effort required	3.29	3.21
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.61	3.54
Outcome depends on the skill and judgment of physician	3.64	3.50
Estimated risk of malpractice suit with poor outcome	3.07	2.96

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.82	3.68
Intra-Service intensity/complexity	3.57	3.36
Post-Service intensity/complexity	3.54	3.50

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.*

A survey was conducted with 54 respondents. Code 32141 was selected as the Key Reference Service, and was performed 2 times annually by the respondents, compared to 3 times for the surveyed code. The vignette was felt to be typical by 93% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 120 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 7 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 27.00 for this code, which is the 25th percentile of the survey values. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

The IWPUT of 32672 is 0.106 compared to the IWPUT of 0.081 for the key reference code 32141, thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure. Compared to the key reference code, the expert panel felt that 32672 was appropriately valued with similar intraoperative time and higher work intensity as reflected by the IWPUT. The higher work intensity reflects the underlying severity of the lung disease and increased risk of post-operative broncho-pleural fistulae.

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) 32999 and 32491

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 cardiothoracic surgery How often? Sometimes

Specialty cardiology How often? Rarely

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 46
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 32 Percentage 69.56 %

Specialty cardiology Frequency 8 Percentage 17.39 %

Specialty other Frequency 7 Percentage 15.21 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 34 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 Utilization data for the corresponding open code 32491 is 104. It is estimated that 1/3 of these procedures (34) will be preformed with the new code 32672.

Specialty cardiothoracic surgery Frequency 24 Percentage 70.58 %

Specialty cardiology Frequency 6 Percentage 17.64 %

Specialty other Frequency 5 Percentage 14.70 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32141

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32673 Tracking Number II20 Original Specialty Recommended RVU: **21.13**
Presented Recommended RVU: **21.13**
Global Period: 090 RUC Recommended RVU: **21.13**

CPT Descriptor: Thoracocopy, surgical; with resection of thymus, unilateral or bilateral
(For open thymectomy see 60520, 60521, 60522)
(For open excision mediastinal cyst see 39200, for open excision mediastinal tumor use 39220)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 35-year-old male with myasthenia gravis is referred for thymectomy.

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 100% , 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) 100%

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 100%

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: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the mediastinum. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then properly positions the patient on the operating table, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.,) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1or 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes

both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The thymus and attached mediastinal fat is carefully dissected off the pericardium from the diaphragm up to the innominate vein. The phrenic nerve is carefully protected. The innominate vein is skeletonized and venous tributaries are ligated or clipped. The two cervical lobes are dissected out above the innominate vein and brought down into the mediastinal space. The pleura on the opposite side is dissected off the thymus and the remainder of the thymus separated from its mediastinal attachments. On occasion it may be necessary to place a trocar in the contralateral pleural space to complete the dissection of the contralateral portion of the thymus gland. The thymus is placed in a sterile bag to avoid trocar site contamination. The operative field is inspected for adequate hemostasis. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. The anesthetist is asked to inflate the lung. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress, and when ready the patient is discharged. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for on-going outpatient pulmonary rehabilitation and additional follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32673					
Sample Size:	300	**Resp N:**	54	**Response:** 18.0 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	5.00	18.00
Survey RVW:	15.00	21.13	**27.75**	30.40	55.00
Pre-Service Evaluation Time:			**60.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	60.00	120.00	**150.00**	180.00	240.00

Immediate Post Service-Time:	**30.00**	
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):	**115.00**	99231x **1.00** 99232x **1.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: 4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32673	**Recommended Physician Work RVU: 21.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**40.00**	**40.00**	**0.00**
Pre-Service Positioning Time:		**15.00**	**3.00**	**12.00**
Pre-Service Scrub, Dress, Wait Time:		**20.00**	**20.00**	**0.00**
Intra-Service Time:		**150.00**		

Immediate Post Service-Time:	**30.00**	
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):	**115.00**	99231x **1.00** 99232x **1.00** 99233x **1.00**
Discharge Day Mgmt:	**38.00**	99238x **1.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**39.00**	99211x **0.00** 12x **1.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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? Yes

KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
39220	090	19.55	**RUC Time**

CPT Descriptor Excision of mediastinal tumor

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44160	090	20.89	**RUC Time**	17,746

CPT Descriptor 1 Colectomy, partial, with removal of terminal ileum with ileocolostomy

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
44140	090	22.59	**RUC Time**	27,635

CPT Descriptor 2 Colectomy, partial; with anastomosis

Other Reference CPT Code	Global	Work RVU	Time Source
60520	090	17.16	**RUC Time**

CPT Descriptor Thymectomy, partial or total; transcervical approach (separate procedure)

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:** 18.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 32673**	**Key Reference CPT Code:** 39220	**Source of Time** **RUC Time**
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	150.00	124.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	115.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**447.00**	**436.00**	
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	3.40
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.60
Urgency of medical decision making	3.00	3.20
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.90	3.60
Physical effort required	3.60	3.40
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.20	3.20
Outcome depends on the skill and judgment of physician	3.80	3.90
Estimated risk of malpractice suit with poor outcome	2.70	2.70

INTENSITY/COMPLEXITY MEASURES	CPT Code	Reference Service 1
Time Segments (Mean)		
Pre-Service intensity/complexity	3.60	3.70
Intra-Service intensity/complexity	3.90	3.90
Post-Service intensity/complexity	3.10	3.00

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.*

A survey was conducted with 54 respondents. 39220 was selected as the Key Reference Service, and was performed 3 times annually by the respondents, compared to 2 times for the surveyed code. The vignette was felt to be typical by 91% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change
Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (150 minutes) and immediate post service time (30 minutes) are recommended, as it a length of stay of 4 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 21.13 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 39220, the expert panel felt 32673 took longer and was of similar intensity (0.081 compared to 0.085 for the reference code). The postoperative care was judged to be about the same and the requirement for office visits similar. Two office visits are required to ensure proper wound healing, remove sutures, monitor the chest radiograph, discuss pathologic results with the patient, monitor the neurologic status of the patient and communicate with the referring neurologist.

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) 32999, 60521 or 60522

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Rarely

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 213
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 180 Percentage 84.50 %

Specialty general surgery Frequency 19 Percentage 8.92 %

Specialty other Frequency 15 Percentage 7.04 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 162
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The open thymectomy codes are currently reported using codes 60521 (319) and 60522 (167) for a total volume of 2009 utilization of 486. It is estimated that 1/3 of each these procedures (162) will be preformed using the new code 32673.

Specialty cardiothoracic surgery Frequency 135 Percentage 83.33 %

Specialty general surgery Frequency 14 Percentage 8.23 %

Specialty other Frequency 11 Percentage 6.47 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32665

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:32674 Tracking Number II21 Original Specialty Recommended RVU: **4.53**
Presented Recommended RVU: **4.53**
Global Period: ZZZ RUC Recommended RVU: **4.12**

CPT Descriptor: Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)
(On the right, mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament)
(On the left, mediastinal lymph nodes include the aortopulmonary window, subcarinal, paraesophageal, and inferior pulmonary ligament).
(Report 32674 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32505, 32503, 32504, 32666, 32667, 32669, 32663, 32670, 32671)

(To report mediastinal and regional lymphadenectomy via thoracotomy, use 38746)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 59-year-old male who undergoes a thoracoscopic right upper lobectomy (separately reported) for a clinical stage I adenocarcinoma. Clinical guidelines indicate the need for a complete thoracic regional and mediastinal lymphadenectomy. Mediastinal lymph nodes are not included within the proximity of the lobectomy specimen. Mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament. The presence of tumor in any lymph nodes in the mediastinum signifies a significantly worse prognosis and indicates the need for postoperative adjuvant therapy.

For this procedure consider only the work of the thoracoscopic lymphadenectomy as defined above. This is an add-on service.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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: There is no additional pre-service work

Description of Intra-Service Work: In the ipsilateral chest thoracoscopically dissect and remove regional and mediastinal lymph nodes. On the right this includes the separate removal and labeling of lymph nodes from the following locations: paratracheal, subcarinal, inferior pulmonary ligament, paraesophageal, and hilar.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32674					
Sample Size:	300	**Resp N:**	44	**Response:** 14.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	8.00	**25.00**	36.00	85.00
Survey RVW:	1.50	4.53	**6.23**	8.00	21.00
Pre-Service Evaluation Time:			**8.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	15.00	28.00	**30.00**	46.00	90.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: ZZZ Global Code

CPT Code:	32674	**Recommended Physician Work RVU: 4.12**		
		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:		**30.00**		

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32501	ZZZ	4.68	**RUC Time**

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	13,121

CPT Descriptor 1 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35600	ZZZ	4.94	**RUC Time**	2,872

CPT Descriptor 2 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
33518	ZZZ	7.93	**RUC Time**

CPT Descriptor Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (List separately in addition to code for primary procedure)

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:** 20.4 **%**

TIME ESTIMATES (Median)	**CPT Code: 32674**	**Key Reference CPT Code:** 32501	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**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	2.85	2.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.21	2.68
Urgency of medical decision making	2.97	2.71
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.65	3.06
Physical effort required	3.29	2.62
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.32	2.97
Outcome depends on the skill and judgment of physician	3.50	3.09
Estimated risk of malpractice suit with poor outcome	2.71	2.65

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.97	2.62
Intra-Service intensity/complexity	3.47	2.94
Post-Service intensity/complexity	2.62	2.59

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.*

A survey was conducted with 44 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 25 times for the surveyed code. The vignette was

felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time 30 minutes.

We are recommending a work RVU of 4.53 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32501, the expert panel felt 32674 took longer and had somewhat less intensity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38746

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 4935
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 4164 Percentage 84.37 %

Specialty general surgery Frequency 475 Percentage 9.62 %

Specialty other Frequency 296 Percentage 5.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,702 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the existing open code 38746 is 12,699. It is estimated that 30% of the procedures that are currently reported using the open code will now be reported using the new code 32674.

Specialty cardiothoracic surgery Frequency 3123 Percentage 84.35 %

Specialty general surgery Frequency 357 Percentage 9.64 %

Specialty other Frequency 222 Percentage 5.99 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 32501

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:38746 Tracking Number II22 Original Specialty Recommended RVU: **4.49**
Presented Recommended RVU: **4.49**
Global Period: ZZZ RUC Recommended RVU: **4.12**

CPT Descriptor: Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)
(On the right, mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament)
(On the left, mediastinal lymph nodes include the aortopulmonary window, subcarinal, paraesophageal, and inferior pulmonary ligament).
(Report 38746 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 3250X, 32503, 32504)
(To report mediastinal and regional lymphadenectomy via thoracoscopy (VATS), see 32674)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female has a right lower lobectomy by thoracotomy (separately reported) for a clinical stage I adenocarcinoma. Clinical guidelines indicate the need for a complete thoracic regional and mediastinal lymphadenectomy. Mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament. The presence of tumor in any lymph nodes in the mediastinum signifies a significantly worse prognosis and indicates the need for postoperative adjuvant therapy.
For this procedure consider only the work of the open lymphadenectomy as defined above. This is an add-on service.

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

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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: There is no additional pre-service work

Description of Intra-Service Work: In the ipsilateral open chest dissect and remove regional and mediastinal lymph nodes. On the right this includes the separate removal and labeling of lymph nodes from the following locations: paratracheal, subcarinal, inferior pulmonary ligament, paraesophageal, and hilar.

Description of Post-Service Work: There is no additioal post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	38746					
Sample Size:	300	**Resp N:**	44	**Response:** 14.6 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	8.00	**15.00**	26.00	200.00
Survey RVW:	1.32	4.49	**6.00**	7.88	22.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	10.00	20.00	**30.00**	40.00	90.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: ZZZ Global Code

CPT Code:	38746	**Recommended Physician Work RVU: 4.12**		
		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:		**30.00**		

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
32501	ZZZ	4.68	**RUC Time**

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
22525	ZZZ	4.47	**RUC Time**	13,121

CPT Descriptor 1 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
35600	ZZZ	4.94	**RUC Time**	2,872

CPT Descriptor 2 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
33572	ZZZ	6.81	**RUC Time**

CPT Descriptor Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure)

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:** 18.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 38746**	**Key Reference CPT Code:** 32501	**Source of Time** **RUC Time**
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**30.00**	**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	3.13	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.25
Urgency of medical decision making	3.38	3.50
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.50	3.50
Physical effort required	3.25	3.13
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	3.25	3.38
Outcome depends on the skill and judgment of physician	3.50	3.50
Estimated risk of malpractice suit with poor outcome	3.00	3.13

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	3.25	3.25
Intra-Service intensity/complexity	3.25	3.63
Post-Service intensity/complexity	3.38	3.13

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.*

A survey was conducted with 44 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 15 times for the surveyed code. The vignette was

felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time 30 minutes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: 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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38746

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Commonly

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 11993
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 10119 Percentage 84.37 %

Specialty general surgery Frequency 1155 Percentage 9.63 %

Specialty other Frequency 719 Percentage 5.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,997
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the existing open code 38746 is 12,699. It is estimated that 70% will remain in 38746.

Specialty cardiothoracic surgery Frequency 7590 Percentage 84.36 %

Specialty general surgery Frequency 866 Percentage 9.62 %

Specialty other Frequency 541 Percentage 6.01 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 38746

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/Specialty Society RVS Update Committee Recommendation

ISSUE: Lung Resection Procedures

TAB: 9

Source	CPT	DESC	global	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME EVAL	PRE-TIME POSIT	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	#	13	12	11
SVY	32096	Thoracotomy, dx biopsy(ies) lung infiltrate(s) , unilateral	90	84	0.149	11.00	17.00	21.13	27.05	40.00	451	55	15	20	35	60	60	90	180	30			2	2	1	1.0		1				
REC	32096		90		0.086			17.00			436	40	15	20			60			30			2	2	1	1.0		1				
SVY	32097	Thoracotomy, dx biopsy(ies) lung nodule(s) or mass(es) unilateral	90	83	0.124	12.00	17.00	20.00	24.69	45.00	411	50	15	20	40	60	80	90	200	30			1	2	1	1.0		1				
REC	32097		90		0.089			17.00			401	40	15	20			80			30			1	2	1	1.0		1				
SVY	32505	Thoracotomy therapeutic wedge resection, initial	90	91	0.139	12.00	18.79	23.18	27.00	40.00	442	55	15	20	42	68	90	90	210	30			1	2	1	1.0		1	1			
REC	32505		90		0.094			18.79			427	40	15	20			90			30			1	2	1	1.0		1	1			
SVY	32506	Thoracotomy; therapeutic wedge resection each additional resection,	ZZZ	42	0.176	1.25	3.50	4.50	7.00	17.00	30	5	0	0	10	15	25	40	90	0											
REC	32506		ZZZ		0.120			3.00			25	0	0	0			25			0											
SVY	32507	Thoracotomy;dx wedge followed by anatomic lung resection	ZZZ	43	0.150	1.25	3.78	4.72	8.00	21.50	40	10	0	0	5	20	30	45	90	0											
REC	32507		ZZZ		0.126			3.78			30	0	0	0			30			0											
SVY	32098	Thoracotomy, with biopsy(ies) of pleura	90	84	0.163	10.00	14.99	18.00	22.85	40.00	340	50	15	20	23	59	60	90	180	30			1	1	1	1.0		1				
REC	32098		90		0.109			14.99			341	40	15	20			60			30			1	1	1	1.0		1				
SVY	32100	Thoracotomy; with exploration	90	85	0.152	13.88	17.50	24.00	29.00	45.00	431	60	15	20	30	60	90	120	195	30			1	2	1	1.0		1				
REC	32100		90		0.079			17.00			411	40	15	20			90			30			1	2	1	1.0		1				
SVY	32607	Thoracoscopy; with dx biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral	0	50	0.207	5.25	9.00	12.50	15.00	40.00	178	28	15	20	10	30	45	60	120	30			1									
REC	32067		0		0.051			5.50			178	28	15	20			45			30			1									
SVY	32608	Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral	0	50	0.179	5.25	12.00	14.00	16.00	40.00	195	30	15	20	15	45	60	60	135	30			1									
REC	32608		0		0.060			6.84			195	30	15	20			60			30			1									
SVY	32666	Thoracoscopy, therapeutic wedge resection initial unilateral	90	55	0.150	11.00	14.50	19.00	24.06	40.00	337	50	15	15	40	60	75	90	210	30			1		1	1.0		1	1			
REC	32666		90		0.093			14.50			332	40	15	20			75			30			1		1	1.0		1	1			
SVY	32667	Thoracoscopy, with therapeutic wedge resection each additional	ZZZ	44	0.177	1.25	3.81	4.59	7.98	20.00	33	8	0	0	5	20	25	33	90	0											
REC	32667		ZZZ		0.120			3.00			25	0	0	0			25			0											

AMA/Specialty Society RVS Update Committee Recommendation

ISSUE: Lung Resection Procedures

TAB: 9

Source	CPT	DESC	global	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME EVAL	PRE-TIME POSIT	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	#	13	12	11
SVY	32668	Thoracoscopy, dx wedge followed by anatomic lung resection	ZZZ	44	0.168	1.25	4.00	5.25	8.75	23.00	40	10	0	0	5	20	30	45	90	0											
REC	32668		ZZZ		0.133			4.00			30	0	0	0			30			0											
SVY	32601	Thoracoscopy, dx, lung, pericardial sac, mediastinal or pleural space, w/out bx	0	50	0.180	5.25	12.00	14.00	16.38	40.00	193	28	15	20	10	45	60	71	120	30				1							
REC	32601		0		0.039			5.50			193	28	15	20			60			30				1							
SVY	32609	Thoracoscopy; with biopsy(ies) of pleura	0	50	0.196	4.95	9.00	12.00	14.94	40.00	178	28	15	20	10	30	45	60	120	30				1							
REC	32609		0		0.031			4.58			178	28	15	20			45			30				1							
SVY	32670	Thoracoscopy, bilobectomy	90	55	0.131	23.00	29.75	35.00	40.75	60.00	547	60	15	15	60	150	180	205	360	30			2	1	1	1.0			1	1	
REC	32670		90		0.098			28.52			532	40	15	20			180			30			2	1	1	1.0			1	1	
SVY	32671	Thoracoscopy, pneumonectomy	90	55	0.123	27.00	31.92	38.00	44.77	63.04	617	60	15	15	60	140	180	180	360	30	1		2	1	1	1.0			1	1	
REC	32671		90		0.092			31.92			602	40	15	20			180			30	1		2	1	1	1.0			1	1	
SVY	32672	Thoracoscopy, LVRS, unilateral	90	54	0.110	14.99	27.00	28.00	32.83	64.00	585	60	15	18	45	90	120	120	240	30			3	2	1	1.0			1	1	
REC	32672		90		0.106			27.00			567	40	15	20			120			30			3	2	1	1.0			1	1	
SVY	32673	Thoracoscopy, resection of thymus, bilateral	90	54	0.123	15.00	21.13	27.75	30.40	55.00	462	60	15	15	60	120	150	180	240	30		1	1	1		1.0		1	1		
REC	32673		90		0.081			21.13			447	40	15	20			150			30		1	1	1		1.0		1	1		
SVY	32669	Thoracoscopy (segmentectomy)	90	54	0.118	17.62	26.00	29.00	35.00	44.00	517	60	15	15	60	120	150	180	255	30			2	1	1	1.0			1	1	
REC	32669		90		0.084			23.53			502	40	15	20			150			30			2	1	1	1.0			1	1	
SVY	32663	Thoracoscopy, with lobectomy	90	55	0.127	25.00	27.23	31.00	36.98	45.88	522	60	15	15	60	143	155	180	360	30			2	1	1	1.0			1	1	
REC	32663		90		0.088			24.64			507	40	15	20			155			30			2	1	1	1.0			1	1	
SVY	32674	Thoracoscopy, lymphadenectomy	ZZZ	44	0.202	1.50	4.53	6.23	8.00	21.00	38	8	0	0	15	28	30	46	90	0											
REC	32674		ZZZ		0.137			4.12			30	0	0	0			30			0											
SVY	38746	thoracotomy, lymphadenectomy	ZZZ	44	0.196	1.32	4.49	6.00	7.88	22.00	35	5	0	0	10	20	30	40	90	0											
REC	38746		ZZZ		0.137			4.12			30	0	0	0			30			0											

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

CPT Long Descriptor:

Diagnostic Throacoscopy Codes

32601	Thoracoscopy, diagnostic, (separate procedure); lung, pericardial sac, mediastinal or pleural space, without biopsy
32607	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
32608	Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
32609	Thoracoscopy; with biopsy(ies) of pleura

Thoracotomy Codes

32096	Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
32097	Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
32098	Thoracotomy, with biopsy(ies) of pleura
32505	Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial
32100	Thoracotomy; with exploration

Surgical Thoracoscopy Codes

32666	Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral
32669	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)
32663	Thoracoscopy, surgical; with lobectomy (single lobe)
32670	Thoracoscopy, surgical; with removal of two lobes (bilobectomy)
32671	Thoracoscopy, surgical; with removal of lung (pneumonectomy)
32672	Thoracoscopy, surgical; with excision/resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed
32673	Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral

Global Period: 090

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

An Expert Panel of cardiothoracic surgeons was used to develop the Practice Expense recommendations

The panel reviewed the RUC standard values, discussed current practice patterns and standards and determined that current RUC standard values for 90 day global procedures were appropriate.

For the 0 day globals, need the following: Although 32601, 32607, 32608, and 32609 are currently defined as 0 day globals, these are anomalous codes. These patients all undergo operative procedures in the Operating Room under general anaesthesia so all scheduling, coordinating, patient education/obtain consent and follow-up office

activities that are routine for other operative procedures (e.g., 32095; "Open thoracotomy for biopsy of lung or pleura") must be carried out for these procedues. These activities are deleniated below in the preservice section. It is relevant to note that when we surveyed our members for physician work estimation, they reported that this procedure was typically associated with 2 to 3 hospital days. We realize that E&M codes can be billed for office activities and hospital visits but this office clinical work can only be captured by including it in the value of the code.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Thoracotomy codes (32096, 32097, 32098, 32505, 32100)

The clinical staff fills out the pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility. They will also coordinate with anesthesia, and the operating room. The clinical staff will educate the patient on what they need to do to prepare for surgery. The staff ensures the patient and family fully understand the procedure and the recovery afterwards and obtain the operative consent. They make follow-up phone calls to the patient and the office of referring physicians and call in needed prescriptions.

Diagnostic thoracoscopy (32601, 3260X, 3260X1, 3260X2) and surgical thoracoscopy codes (32666, 32669, 32663, 32670, 32671, 32672 32673)

The clinical staff fills out the pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility. They will also coordinate with anesthesia, and the operating room. The operating room coordinating requires ensuring the needed video equipment and minimally invasive instrumentation are available and present. The clinical staff will educate the patient on what they need to do to prepare for surgery. The staff ensures the patient and family fully understand the procedure and the recovery afterwards and obtain the operative consent. They make follow-up phone calls to the patient and the office of referring physicians and call in needed prescriptions.

Intra-Service Clinical Labor Activities:

Thoracotomy codes (32096, 32097, 32098, 32505, 32100)

Surgical thoracoscopy codes (32666, 32669, 32663, 32670, 32671, 32672 32673)

Office staff participate in discharge day management activities including coordination of home health services, phoning in prescriptions, reviewing and emphasizing follow-up instructions, notifying the office of the referring physician, coordinating follow-up office visits and answering patient and family questions.

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**THORACOSCOPY, DIAGNOSTIC**			
2				**II8**	**II9**	**II10**	**II11**
3	**Meeting Date: April 2011**			**32601**	**32607**	**32608**	**32609**
4	**Specialty: STS**			Thoracoscopy, diagnostic, (separate procedure); lungs,	Thoracoscopy, diagnostic; with biopsy(ies) of lung infiltrate	Thoracoscopy, diagnostic; with biopsy(ies) of lung	Thoracoscopy, diagnostic; with biopsy(ies) of pleura
5	**LOCATION**	**Code**	**Staff Type**	**FAC**	**FAC**	**FAC**	**FAC**
6	**GLOBAL PERIOD**			**000**	**000**	**000**	**000**
7	**TOTAL CLINICAL LABOR TIME**	**L051A**	**RN**	**60**	**60**	**60**	**60**
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L051A**	**RN**	**60**	**60**	**60**	**60**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L051A**	**RN**	**0**	**0**	**0**	**0**
10	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L051A**	**RN**	**0**	**0**	**0**	**0**
11	**PRE-SERVICE**						
12	**Start: Following visit when decision for surgery or procedure made**						
13	Complete pre-service diagnostic & referral forms	**L051A**	**RN**	**5**	**5**	**5**	**5**
14	Coordinate pre-surgery services	**L051A**	**RN**	**20**	**20**	**20**	**20**
15	Schedule space and equipment in facility	**L051A**	**RN**	**8**	**8**	**8**	**8**
16	Provide pre-service education/obtain consent	**L051A**	**RN**	**20**	**20**	**20**	**20**
17	Follow-up phone calls & prescriptions	**L051A**	**RN**	**7**	**7**	**7**	**7**
19	**End:When patient enters office/facility for surgery/procedure**						
20	**SERVICE PERIOD**						
21	**Start: When patient enters site for procedure: Services Prior to Procedure**						
39	Discharge day management	**L051A**	**RN**				
41	**End: Patient leaves office**						
42	**POST-SERVICE Period**						
43	**Start: Patient leaves office/facility**						
45	*Office visits:*						
46	*List Number and Level of Office Visits*						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36				
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	***Total Office Visit Time***	**L051A**	**RN**	**0**	**0**	**0**	**0**
54	***Other Total:***						
55	**End: with last office visit before end of global period**						
56	**MEDICAL SUPPLIES**	**Code**	**Unit**				
57	pack, minimum multi-specialty visit	**SA048**	**pack**				
58	pack, post-op incision care (suture & staple)	**SA053**	**pack**				
59	**Equipment**	**Code**					
60	table, power	**EF031**					
61	light, surgical	**EF014**					

	A	B	C	H	I	J	K	L	M	N
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**THORACOSCOPY, SURGICAL**						
2				**II12**	**II15**	**IIY16**	**II17**	**II18**	**II19**	**II20**
3	**Meeting Date: April 2011**			**32666**	**32669**	**32663**	**32670**	**32671**	**32672**	**32673**
4	**Specialty: STS**			Thoracoscopy, surgical; with diagnostic or therapeutic wedge	Thoracoscopy, surgical; with removal of a single lung segment (segmentecto	Thoracoscopy, surgical; with lobectomy (single lobe)	Thoracoscopy, surgical; with removal of two lobes (bilobectomy)	Thoracoscopy, surgical; with removal of lung, pneumonecto	Thoracoscopy, surgical; with excision/resection-plication for	Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral
5	**LOCATION**	**Code**	**Staff Type**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**
6	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**090**	**090**
7	**TOTAL CLINICAL LABOR TIME**	**L051A**	**RN**	**135**	**135**	**135**	**135**	**135**	**135**	**135**
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L051A**	**RN**	**60**	**60**	**60**	**60**	**60**	**60**	**60**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L051A**	**RN**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
10	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L051A**	**RN**	**63**	**63**	**63**	**63**	**63**	**63**	**63**
11	**PRE-SERVICE**									
12	**Start: Following visit when decision for surgery or procedure made**									
13	Complete pre-service diagnostic & referral forms	**L051A**	**RN**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
14	Coordinate pre-surgery services	**L051A**	**RN**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
15	Schedule space and equipment in facility	**L051A**	**RN**	**8**	**8**	**8**	**8**	**8**	**8**	**8**
16	Provide pre-service education/obtain consent	**L051A**	**RN**	**20**	**20**	**20**	**20**	**20**	**20**	**20**
17	Follow-up phone calls & prescriptions	**L051A**	**RN**	**7**	**7**	**7**	**7**	**7**	**7**	**7**
19	**End:When patient enters office/facility for surgery/procedure**									
20	**SERVICE PERIOD**									
21	**Start: When patient enters site for procedure: Services Prior to Procedure**									
39	Discharge day management	**L051A**	**RN**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
41	**End: Patient leaves office**									
42	**POST-SERVICE Period**									
43	**Start: Patient leaves office/facility**									
45	*Office visits:*									
46	*List Number and Level of Office Visits*									
47	99211 16 minutes		16							
48	99212 27 minutes		27	**1**	**1**	**1**	**1**	**1**	**1**	**1**
49	99213 36 minutes		36	**1**	**1**	**1**	**1**	**1**	**1**	**1**
50	99214 53 minutes		53							
51	99215 63 minutes		63							
52	Other									
53	***Total Office Visit Time***	**L051A**	**RN**	**63**	**63**	**63**	**63**	**63**	**63**	**63**
54	***Other Total:***									
55	**End: with last office visit before end of global period**									
56	**MEDICAL SUPPLIES**	**Code**	**Unit**							
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**2**	**2**	**2**	**2**	**2**	**2**	**2**
58	pack, post-op incision care (suture & staple)	**SA053**	**pack**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
59	**Equipment**	**Code**								
60	table, power	**EF031**		**63**	**63**	**63**	**63**	**63**	**63**	**63**
61	light, surgical	**EF014**		**63**	**63**	**63**	**63**	**63**	**63**	**63**

	A	B	C	O	P	Q	R	S	T	U	V	W	X	Y
1	**AMA/Specialty Society RVS Update Committee Recommendation**			**THORACOTOMY**					**ADD-ON**					
2				**II1**	**II2**	**II3**	**II4**	**II5**	**II6**	**II7**	**II13**	**II14**	**II21**	**II22**
3	**Meeting Date: April 2011**			**32096**	**32097**	**32098**	**32100**	**32505**	**32506**	**32507**	**32667**	**32668**	**32674**	**38746**
4	**Specialty: STS**			Thoracotomy, with biopsy(ies) of lung infiltrate(s)	Thoracotomy, with biopsy(ies) of lung nodule(s) or	Thoracotomy, with biopsy(ies) of pleura	Thoracotomy; with exploration	Thoracotomy; with diagnostic or therapeutic wedge	Thoracotomy; with diagnostic or therapeutic wedge	Thoracotomy; with diagnostic wedge resection	Thoracoscopy, surgical; with diagnostic or therapeutic wedge	Thoracoscopy, surgical; with diagnostic wedge resection	Thoracoscopy, surgical; with mediastinal and regional lymphadenec	Thoracic lymphadenectomy by thoracotomy, mediastinal
5	**LOCATION**	**Code**	**Staff Type**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**	**FAC**
6	**GLOBAL PERIOD**			**090**	**090**	**090**	**090**	**090**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
7	**TOTAL CLINICAL LABOR TIME**	**L051A**	**RN**	**108**	**108**	**108**	**108**	**135**	**0**	**0**	**0**	**0**	**0**	**0**
8	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L051A**	**RN**	**60**	**60**	**60**	**60**	**60**	**0**	**0**	**0**	**0**	**0**	**0**
9	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L051A**	**RN**	**12**	**12**	**12**	**12**	**12**	**0**	**0**	**0**	**0**	**0**	**0**
10	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L051A**	**RN**	**36**	**36**	**36**	**36**	**63**	**0**	**0**	**0**	**0**	**0**	**0**
11	**PRE-SERVICE**													
12	**Start: Following visit when decision for surgery or procedure made**													
13	Complete pre-service diagnostic & referral forms	**L051A**	**RN**	**5**	**5**	**5**	**5**	**5**	**0**	**0**	**0**	**0**	**0**	**0**
14	Coordinate pre-surgery services	**L051A**	**RN**	**20**	**20**	**20**	**20**	**20**	**0**	**0**	**0**	**0**	**0**	**0**
15	Schedule space and equipment in facility	**L051A**	**RN**	**8**	**8**	**8**	**8**	**8**	**0**	**0**	**0**	**0**	**0**	**0**
16	Provide pre-service education/obtain consent	**L051A**	**RN**	**20**	**20**	**20**	**20**	**20**	**0**	**0**	**0**	**0**	**0**	**0**
17	Follow-up phone calls & prescriptions	**L051A**	**RN**	**7**	**7**	**7**	**7**	**7**	**0**	**0**	**0**	**0**	**0**	**0**
19	**End:When patient enters office/facility for surgery/procedure**													
20	**SERVICE PERIOD**													
21	**Start: When patient enters site for procedure: Services Prior to Procedure**													
39	Discharge day management	**L051A**	**RN**	**12**	**12**	**12**	**12**	**12**						
41	**End: Patient leaves office**													
42	**POST-SERVICE Period**													
43	**Start: Patient leaves office/facility**													
45	*Office visits:*													
46	*List Number and Level of Office Visits*													
47	99211 16 minutes		16											
48	99212 27 minutes		27					**1**						
49	99213 36 minutes		36	**1**	**1**	**1**	**1**	**1**						
50	99214 53 minutes		53											
51	99215 63 minutes		63											
52	Other													
53	***Total Office Visit Time***	**L051A**	**RN**	**36**	**36**	**36**	**36**	**63**	**0**	**0**	**0**	**0**	**0**	**0**
54	***Other Total:***													
55	**End: with last office visit before end of global period**													
56	**MEDICAL SUPPLIES**	**Code**	**Unit**											
57	pack, minimum multi-specialty visit	**SA048**	**pack**	**1**	**1**	**1**	**1**	**2**						
58	pack, post-op incision care (suture & staple)	**SA053**	**pack**	**1**	**1**	**1**	**1**	**1**						
59	**Equipment**	**Code**												
60	table, power	**EF031**		**36**	**36**	**36**	**36**	**63**						
61	light, surgical	**EF014**		**36**	**36**	**36**	**36**	**63**						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2010

Multi-Layer Compression System

In June 2010, the CPT Editorial Panel revised code 29581and created three new codes to describe the application of multi-layer compression to the upper and lower extremities, not just below the knee. Multi-layer compression systems are used to treat edema for a variety of indications, not just venous leg ulcers.

29581
The CPT Editorial Panel determined the revisions to the descriptor for 29581 were editorial when multi-layer compression codes for other body areas were created. Additionally, no changes were made to the vignette and therefore the specialty society explained that resurveying this code was not necessary. The RUC agreed that the changes to 29581 were editorial. The RUC noted that code 29581 was intended predominantly for venous ulcer therapy and includes ulcer related care in addition to compression. **The RUC recommends that the changes to 29581 were editorial and to maintain the work RVU of 0.60 for CPT code 29581.**

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
29540		Strapping; ankle and/or foot (Do not report 29540 in conjunction with 29581, 29582)	000	0.51 (No Change)
29580		Unna boot (Do not report 29580 in conjunction with 29581, 29582)	000	0.55 (No Change)
▲29581	A1	Application of multi-layer ~~venous wound~~ compression system~~, below knee~~; leg (below knee), including ankle and foot (Do not report 29581 in conjunction with 29540, 29580, 29582, 36475, 36478, 97140)	000	0.60 (No Change)

CPT Code (•New)	Track-ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●29582	A2	thigh and leg, including ankle and foot, when performed (Do not report 29582 in conjunction with 29540, 29580, 29581, 36475, 36478, 97140)	000	0.35 (HCPAC Recommendation)
●29583	A3	upper arm and forearm (Do not report 29583 in conjunction with 29584, 97140)	000	0.25 (HCPAC Recommendation)
●29584	A4	upper arm, forearm, hand, and fingers (Do not report 29584 in conjunction with 29583, 97140)	000	0.35 (HCPAC Recommendation)

SVS®
Society for Vascular Surgery

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August 24, 2010

Barbara Levy, MD
Chair, AMA/Specialty Society Relative Value Scale Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60610

Dear Dr. Levy:

CPT code 29581 (Application of multi-layer venous wound compression system, below knee) was evaluated by the CPT Editorial panel in June 2010 along with 3 new CPT codes in the same family. The RUC originally asked the specialties to bring to the October 2010 RUC meeting a work RVU recommendation on all four of these CPT codes. However, at its June 2010 meeting, the CPT Editorial Panel's final determination was that that the recent code description changes to CPT code 29581 were editorial and no changes were made to the typical patient vignette, so revaluing of this CPT code was not necessary. Therefore, the specialties determined that a survey and recommendation of CPT code 29581 was not required.
Sincerely,

Gary Seabrook, MD
SVS RUC Advisor

Sean Roddy, MD
SVS CPT Advisor

Health Care Professionals Advisory Committee (HCPAC) Summary of Recommendations
Identified as part of the CMS Fastest Growing Screen

April 2011

Otoacoustic Emissions Measurement

In October 2008, CMS identified code 92587 as part of the CMS Fastest Growing screen. In February 2010, the specialty society surveyed this service, however, after reviewing the survey data, agreed that more than one service is being represented under this code and requested the service be referred back to the CPT Editorial Panel for further clarification. The HCPAC referred code 92587 to the CPT Editorial Panel to clearly describe the services being performed.

The specialty society indicated that the explanation for the increased utilization in Medicare eligible adults reveals two distinct clinical practice patterns. The first area is the use of the procedure for early detection of hearing loss in newborns and young children who cannot perform the tasks associated with standard audiometry. The second area is the increasingly common application to determine whether there is a cochlear site of involvement for older children and hearing impaired adults as well as an objective evaluation of cochlear function in adults who are experiencing hearing loss, tinnitus, and/or the ototoxic effects of medications or other toxins. The practice patterns and use of clinical staff are also quite different between the two broad areas (screening vs. diagnosis) of application. When used for screening, the procedure is commonly performed by a medical technician or nurse under the supervision of an audiologist or physician. In contrast, when used for diagnosis, audiologists typically perform this procedure personally in the clinical or office setting as part of a multi-test diagnostic evaluation of auditory status. Therefore, in February 2011, the CPT Editorial Panel created one new code to describe the screening and revised two codes to clarify the otoaucoustic emissions evaluations.

92558 ***Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis***
The HCPAC reviewed the survey results from 111 audiologists and compared 92558 to the key reference code 92567 *Tympanometry (impedance testing)* (work RVU = 0.20). The survey respondents indicated, and the HCPAC agreed, that the surveyed code requires less intensity and complexity to perform than the key reference code. The HCPAC compared 92558 to other similar services such as 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = 0.17 and 5 minutes intra-service time and 2 minutes immediate post-service time), 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (work RVU = 0.17 and 7 minutes intra-service time) and 11719 *Trimming of nondystrophic nails, any number* (work RVU = 0.17 and 2 minutes pre-service, 2 minutes intra-service and 5 minutes immediate post-service time). The HCPAC noted that this service is automated, but unlike 76977 *Ultrasound bone density measurement and interpretation, peripheral site(s), any method* (work RVU = 0.05) and 95905 *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report* (work RVU = 0.05), code 92558 requires continual placement of

the probe and the application of the test for a baby by a qualified health care professional. **The HCPAC recommends 5 minutes intra-service time and 2 minutes immediate post-service time and a work RVU of 0.17 for CPT code 92558.**

92587 ***Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report***
The HCPAC reviewed the survey results from 186 audiologists and determined that 92587 is less intense and complex, as seen in the intensity/complexity measures, compared to key reference code 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* (work RUC = 0.55 and 3 minutes pre-service, 15 minutes intra-service and 3 minutes immediate post-service time). The HCPAC agreed that 3 minutes pre-service, 12 minutes intra-service and 3 minutes immediate post-service time appropriately accounts for the time required to perform this evaluation. The audiologist is not only constantly monitoring the positioning of the patient and placement of the probe, but is making clinical observations of the patient throughout the test to identify any false positives from the automated examination. The HCPAC determined that the work required to perform 92587 falls between the survey 25th percentile and median, 0.35 and 0.55, respectively. The HCPAC determined that 0.45 work RVUs appropriately accounts for the work required to perform this service and therefore be directly crosswalked to 97110 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility* (work RVU = 0.45). The HCPAC indicated that the recommended work RVU of 0.45 appropriately places this service relative to other similar services, 92250 *Fundus photography with interpretation and report* (work RVU = 0.35) and key reference service 92570 (work RVU = 0.55). **The HCPAC recommends a work RVU of 0.45 for CPT code 92587.**

92588 ***Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report***
The HCPAC reviewed the survey results of 96 audiologists and compared 92588 to key reference service 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* (work RUC = 0.55 and 3 minutes pre-service, 15 minutes intra-service and 3 minutes immediate post-service time). The survey respondents indicated, and the HCPAC agreed that 92588 is more intense and complex to perform than the reference service code 92570. The HCPAC agreed that 3 minutes pre-service, 16.5 minutes intra-service and 3 minutes immediate post-service time appropriately accounts for the time required to perform this evaluation. The HCPAC determined that 92558 and 92557 *Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)* (work RVU = 0.60) require the same work and be directly crosswalked, which was supported by the survey median of 0.62. **The HCPAC recommends a work RVU of 0.60 for CPT code 92588.**

Practice Expense
The Practice Expense Subcommittee reviewed and the HCPAC agreed with the medical supplies and equipment inputs as recommended by the specialty society. The HCPAC noted that there are no clinical labor inputs as all the professional work is now captured in the work component and not in the practice expense component.

CPT Code (•New)	Track-ing Num-ber	CPT Descriptor	Global Period	Work RVU Recommendation
●92558	DD1	Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	XXX	0.17
▲92587	DD2	Distortion product evoked otoacoustic emissions; limited evaluation (~~single stimulus level, either transient or distortion products~~ to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	XXX	0.45
▲92588	DD3	comprehensive ~~or~~ diagnostic evaluation (~~comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies~~ quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report (For central auditory function evaluation, see 92620, 92621)	XXX	0.60

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92558 Tracking Number DD1 Original Specialty Recommended RVU: **0.25**
Presented Recommended RVU: **0.25**
Global Period: XXX RUC Recommended RVU: **0.17**

CPT Descriptor: Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-week-old girl is being seen by her pediatrician because she did not pass a previous hearing screening at birth.

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

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? 1%

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: The qualified healthcare professional prepares the equipment and prepares it to perform an automated otoacoustic emission screening protocol, which automatically performs the test and records the responses.

Description of Intra-Service Work: A qualified healthcare professional performs an otoscopic examination of each ear. An appropriately sized probe tip is selected and placed securely into each ear canal. An automated otoacoustic emission (OAE) screening protocol is initiated to stimulate the test and record the responses. The emissions are evaluated by the device in accordance with an automated algorithm. The qualified healthcare professional monitors the responses in accordance with automated algorithms. The algorithm determines the emissions to be present or not, yielding a result of pass or refer.

Description of Post-Service Work: After the test has been completed for each ear and the results are printed, the qualified healthcare professional reviews the results in light of any risk factors for hearing loss, completes the appropriate documentation in the child's medical chart, and informs the family of the test outcome.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Robert Fifer, PhD, Paul Pessis, AuD					
Specialty(s):	Audiology					
CPT Code:	92558					
Sample Size:	368	**Resp N:**	111	**Response:** 30.1 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**50.00**	112.00	5500.00
Survey RVW:	0.15	0.25	**0.30**	0.40	2.90
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**10.00**	15.00	30.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	92558	**Recommended Physician Work RVU: 0.17**		
		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:		**5.00**		

Immediate Post Service-Time:	**2.00**	
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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
92567	XXX	0.20	**RUC Time**

CPT Descriptor Tympanometry (impedance testing)

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11719	000	0.17	**RUC Time**	1,472,007

CPT Descriptor 1 Trimming of nondystrophic nails, any number

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95831	XXX	0.30	**Other**	47,303

CPT Descriptor 2 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk

Other Reference CPT Code	Global	Work RVU	Time Source
		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: 59 **% of respondents:** 53.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 92558**	**Key Reference CPT Code:** 92567	**Source of Time RUC Time**
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	5.00	4.00	
Median Immediate Post-service Time	2.00	1.00	
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 Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**7.00**	**6.00**	

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	2.42	2.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.42	2.36
Urgency of medical decision making	3.03	2.76
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.36	2.58
Physical effort required	1.83	1.88
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.71	1.54
Outcome depends on the skill and judgment of physician	2.36	2.54
Estimated risk of malpractice suit with poor outcome	2.14	1.76

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	1.95	1.90
Intra-Service intensity/complexity	2.61	2.34
Post-Service intensity/complexity	2.24	2.19

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.*

We are citing two MPC codes as further support: Code 11719, trimming of nondystrophic nails, RVW of 0.17 with 2 minutes of intra time and Code 95831, Muscle testing, manual (separate procedure) with report, extremity or trunk, with an RVW of 0.28 and total time of 16 minutes.

Other codes we cite in support of the recommended RVW include Code 92081 (Visual field examination, unilateral or bilateral, with interpretation and report; limited examination), which is assigned an RVW of 0.30 for 7 minutes of intra time; Code 71020 (Radiologic examination, chest, 2 views, frontal and lateral), RVW=0.22 with 3 minutes of intra time; Code 88311 (Decalcification procedure), RVW=0.24 with 5 minutes of intra time; and Code 93922 (Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries), RVW=0.25 with 5 minutes of intra 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) 92587

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 audiology How often? Commonly

Specialty otorhinolaryngology How often? Rarely

Specialty pediatrics How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 57158
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This number was derived from the total estimated number of children who failed newborn otoacoustic emissions screening and require follow-up. From the Bureau of Vital Statistics, approximately 4.2 million children were born in 2006. Of that number we estimate that approximately 2.9 million children will receive initial screening using otoacoustic emissions. Of that number 2% will require follow-up outpatient testing.

Specialty audiology Frequency 40000 Percentage 69.98 %

Specialty otorhinolaryngology Frequency 5000 Percentage 8.74 %

Specialty pediatrics Frequency 13000 Percentage 22.74 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is a procedure used with infants .

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)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92567

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92587 Tracking Number DD2 Original Specialty Recommended RVU: **0.55**
Presented Recommended RVU: **0.55**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A two-year-old boy is referred by his pediatrician for objective estimation of hearing sensitivity due to delays in speech and language development. Recent attempts to obtain behavioral hearing evaluation results yielded inconclusive information. Supplemental testing is needed to obtain additional information regarding hearing function.

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? 5%

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:
The audiologist performs a chart review. The audiologist accesses the otoacoustic software and the appropriate frequency and signal averaging protocol. The patient's demographic information and medical record number are entered into the testing software and the otoacoustic emission (OAE) screening interface is activated.

Description of Intra-Service Work:
The audiologist briefly affirms key elements of the history and presenting concerns, explains the purpose of the procedure to the patient’s parents or guardian. The audiologist then informs the parent or guardian of what to expect when the test is under way and instructs the parent on the proper positioning of the child throughout the procedure. The audiologist performs an otoscopic examination of each ear, an appropriate-sized probe tip is selected, and the stimulus/recording probe assembly is inserted into the patient's ear canal. Once properly seated, the protocol is activated. Under the constant observation of the audiologist, the testing software performs a calibration to ensure proper probe placement and the absence of blockage. The test protocol continues with the evaluation of the first test frequency. Tonal pairs are presented to the patient's ear; after each presentation the OAE equipment waits approximately 2 to 6 milliseconds to record evidence of sensory cell movement in the cochlea. The process is repeated for approximately 500 samples in order to perform a signal-averaging algorithm to separate the anticipated otoacoustic emission from the noise floor from either the patient or the environment. Once the requisite number of samples is collected for the first frequency pair, the OAE equipment changes frequency pairs according to the selected protocol and repeats the procedure. This algorithm is repeated until data for three

to six frequency pairs are collected. Results are then displayed on the OAE equipment screen by frequency for the otoacoustic emission amplitude and the level of the noise floor in decibels. When the first ear is completed, the process is repeated for the second ear. The audiologist evaluates the data to determine whether a biologic (in contrast to artifactual) response was obtained at each frequency. Results are printed for placement in the patient's medical chart. The audiologist prepares a report describing the measurements, outcomes, and recommendations.

Description of Post-Service Work: Post-service work includes describing the results to the patient's family and notifying the referring physician of the test outcomes.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Robert C. Fifer, PhD; Paul Pessis, AuD					
Specialty(s):	Audiology					
CPT Code:	92587					
Sample Size: 496	**Resp N:** 186	**Response:** 37.5 %				
Sample Type: Panel	**Additional Sample Information:**					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	62.50	**150.00**	340.50	2200.00	
Survey RVW:	0.20	0.35	**0.55**	0.60	60.00	
Pre-Service Evaluation Time:			**5.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	2.00	10.00	**12.00**	15.00	60.00	
Immediate Post Service-Time:	**10.00**					
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** 99217x **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**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	92587	**Recommended Physician Work RVU: 0.45**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**0.00**	**3.00**
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:		**12.00**		
Immediate Post Service-Time:	**3.00**			
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** 99217x **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**		
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
92570	XXX	0.55	**RUC Time**

CPT Descriptor Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99201	XXX	0.48	**RUC Time**	321,183

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires 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.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97002	XXX	0.60	**RUC Time**	401,968

CPT Descriptor 2 Physical therapy re-evaluationl

Other Reference CPT Code	Global	Work RVU	Time Source
93285	XXX	0.52	**RUC Time**

CPT Descriptor Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 71 **% of respondents:** 38.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 92587**	**Key Reference CPT Code:** 92570	**Source of Time RUC Time**
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	12.00	15.00	
Median Immediate Post-service Time	3.00	3.00	
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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**18.00**	**21.00**
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	3.63	3.49
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.49	3.25
Urgency of medical decision making	3.37	3.14
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.61	3.46
Physical effort required	2.61	2.56
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.96	1.92
Outcome depends on the skill and judgment of physician	3.51	3.38
Estimated risk of malpractice suit with poor outcome	2.65	2.38

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.41	2.15
Intra-Service intensity/complexity	3.56	3.42
Post-Service intensity/complexity	3.14	2.83

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.*

We convened an expert panel to review the survey data, obtained from audiologists who volunteered to participate, and develop recommendations for an RVW, PE inputs and pre, intra and post time. We are recommending acceptance of the median intra time of 12 minutes but would reduce the pre and post time to 3 minutes each.

The RVW recommended is identical to the RVW assigned to the key reference code 92570. While the intra time of the reference code is slightly higher (15 compared with 12 minutes), the intensity and complexity measures are consistently higher for the surveyed code. The RVW is further supported by the values assigned to the key MPC codes cited which bracket the recommended RVW. Code 99201, which is a Level 1 office or outpatient visit for a new patient, is assigned an RVW of 0.48 for 10 minutes of intra time and Code 97002 Physical therapy re-evaluation, is assigned an RVW of 0.60 for 18 minutes of intra time.

Finally, we are citing an additional code, 93285 (Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system) which lends further credence to the recommended RVW. This code is assigned an RVW of 0.52 for the same intra time as the surveyed code.

The expert panel noted that some respondents indicated that moderate sedation is used for this procedure. Our expert panel reports that children are never sedated for the sole purpose of performing otoacoustic emissions. If a child is under sedation for another purpose, the audiologist may perform otoacoustic emissions by prior arrangement.

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) 92587

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

Specialty audiology How often? Commonly

Specialty otorhinolaryngology How often? Commonly

Specialty internal medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 200000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty audiology Frequency 54000 Percentage 27.00 %

Specialty otorhinolaryngology Frequency 72000 Percentage 36.00 %

Specialty internal medicine Frequency 46000 Percentage 23.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 57,700 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

Specialty audiology Frequency 15579 Percentage 27.00 %

Specialty otorhinolaryngology Frequency 20772 Percentage 36.00 %

Specialty internal medicine Frequency 13271 Percentage 23.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92587

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:92588 Tracking Number DD3 Original Specialty Recommended RVU: **0.81**
Presented Recommended RVU: **0.81**
Global Period: XXX RUC Recommended RVU: **0.60**

CPT Descriptor: Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

(for central auditory function evaluation, see 92620, 92621)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year old woman with a diagnosis of cancer is referred by her oncologist for a baseline assessment of cochlear hair cell function prior to the initiation of a potentially ototoxic regimen of chemotherapy.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

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? 4%

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: The audiologist performs a chart review. The audiologist selects a specific test protocol for number of octaves to be assessed and the number of frequencies to be evaluated for each octave.

Description of Intra-Service Work: The audiologist performs an otoscopic examination of each ear. Once the appropriate-sized probe tip is selected and placed on the acoustic probe assembly, it is inserted directly into each ear canal. During the test administration the audiologist continually assesses the collected data to determine if changes to the test protocol are warranted. The measurement of distortion product otoacoustic emissions is repeated for multiple frequencies per octave across multiple octaves. The responses are then replicated to establish validity and reliability of the distortion products. The amplitudes of the distortion product otoacoustic emissions relative to the noise floor are evaluated for distinct response patterns signifying frequency regions of good cochlear function, frequency regions where function is compromised but not eliminated, and frequency regions where there is no residual function. The audiologist performs a detailed analysis of the graphic display of these collective responses which constitutes a frequency map of the cochlea consistent with the status of the cochlear outer hair cells. After the protocol has been completed on the first ear, the procedure is repeated for the second ear. When the test protocol has been completed for both ears, the audiologist interprets the test results by comparing the response amplitudes to normative data and/or previous test results. The audiologist then prepares a report for the referring physician.

Description of Post-Service Work: The audiologist reviews the results with the patient. The results are printed and the audiologist finalizes the documentation for entry into the medical chart. The audiologist then sends a report to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Robert C. Fifer, PhD, Paul Pessis, AuD					
Specialty(s):	Audiology					
CPT Code:	92588					
Sample Size:	332	**Resp N:**	96	**Response:** 28.9 %		
Sample Type:	Panel	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	**50.00**	102.50	1576.00
Survey RVW:	0.27	0.55	**0.62**	0.81	70.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.35	11.50	**16.50**	25.00	60.00

Immediate Post Service-Time:	**10.00**	
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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	92588	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**3.00**	**0.00**	**3.00**
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:		**16.50**		

Immediate Post Service-Time:	**3.00**	
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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
92570	XXX	0.55	**RUC Time**

CPT Descriptor Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97755	000	0.62	**RUC Time**	2,397

CPT Descriptor 1 Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
97001	XXX	1.20	**RUC Time**	1,837,218

CPT Descriptor 2 Physical therapy evaluation

Other Reference CPT Code	Global	Work RVU	Time Source
21116	XXX	0.81	**RUC Time**

CPT Descriptor Injection procedure for temporomandibular joint arthrography

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: 32 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)	**CPT Code: 92588**	**Key Reference CPT Code:** 92570	**Source of Time RUC Time**
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	16.50	15.00	
Median Immediate Post-service Time	3.00	3.00	
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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**22.50**	**21.00**
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	3.78	3.41
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	3.22
Urgency of medical decision making	3.53	2.94
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.63	3.31
Physical effort required	2.25	2.16
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.13	1.94
Outcome depends on the skill and judgment of physician	3.75	3.34
Estimated risk of malpractice suit with poor outcome	2.53	2.25

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.56	2.41
Intra-Service intensity/complexity	3.56	3.19
Post-Service intensity/complexity	3.34	3.00

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.*

We convened an expert panel to review the survey data, obtained from audiologists who volunteered to participate, and develop recommendations for an RVW, PE inputs and pre, intra and post time.

We recognize that recommending an RVW above the median value is somewhat unusual and we want to fully explain the rationale for this decision. In our judgment, the main problem is that a number of the survey respondents did not fully appreciate the change in the language to this code compared to Code 92587. The language of 92587 and 92588 was changed because of long-standing confusion as to the distinction between these codes. The original descriptors attempted to take into account two different types of technologies for measuring otoacoustic emissions (transient and distortion product otoacoustic emissions) in each code. The original (current) limited code (92587) descriptor described the procedure in the following manner:

> Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products).

The diagnostic otoacoustic emissions procedure (92588) currently is defined as follows:

> Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies).

When the codes were developed in 1994, transient otoacoustic emissions were the predominant form of testing. Distortion product instruments were just becoming available. Since that time, the use of transient otoacoustic emissions instruments has diminished such that only a very small percentage of audiologists now use that technique. Overwhelmingly, research has emphasized the clinical utility of distortion product otoacoustic measurements. The point is that one of the main tenets of 92588, according to the descriptor, could no longer be met: the comparison of the two measurement techniques. For the majority of audiologists, only distortion product devices are used for which there was no guidance on the number of frequencies necessary to meet requirements for a diagnostic procedure. In the past, many audiologists believed that use of only six frequencies could constitute a diagnostic procedure versus four frequencies for a limited. This was one of the reasons that we made the descriptors for 92587 versus 92588 clearly distinguished based on number of frequencies tested. There is clearly increased professional work as the number of frequencies increase.

With this background, we note that the raw survey data showed confusion between 92587 and 92588 in the minds of a significant number of individuals completing the survey. A review of the raw data revealed that 49 respondents valued 92588 exactly the same as 92587 relative to intra-service times and recommended RVWs. Moreover, the same CPT code, 92570, was the primary reference for 92588 as for 92587. Lastly, the median time for 92588 is 16.50 minutes, not substantially different than the median time for 92587 of 12 minutes. It is noteworthy that the maximum number of frequencies for 92587 is 6 while the minimum number for 92588 is 12. Given that it takes the same amount of time per frequency to collect the data, the intra-service time for 92588 should be substantially longer than for 92587. The 75th percentile median intra-service time for 92588 confirms the premise that the time for the procedure will increase substantially when the number of frequencies increase since it shows 25 minutes compared to 12 minutes for 92587. These arguments support the recommendation of the 75th percentile for intra-service time and RVW for 92588, especially when considering that the interpretation and report are included in the inter-service time in accordance with the survey instrument.

In further support of our recommended RVW, we are citing 2 MPC codes whose RVW's bracket the recommended value. Code 97755 (Assistive technology assessment) with an RVW of 0.62 and 15 minutes of intra time and Code 97001 (Physical therapy evaluation), with an RVW of 1.20 and 30 minutes of intra time. An additional comparison code that supports the recommendation includes: 21116 (Injection procedure for temporomandibular joint arthrography; RVW=0.81 with 25 minutes of intra 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: 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 may be reported with 92552 (Pure tone audiometry (threshold); air only) in order to document hearing sensitivity in addition to the status of sensory cell structure in the cochlea.

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 may be reported with 92552 (Pure tone audiometry (threshold); air only) in order to document hearing sensitivity in addition to the status of sensory cell structure in the cochlea. CPT 92552 does not contain physician work and has a non-facility PE RVU of 0.74 and 26 minutes of intra for clinical staff time.

CPT Code	Global Period	RVW	Pre-Service	Intra-Service	Post-Service	Total Time
92588	XXX	0.81	4	25	5	34
92552	XXX	0.00	0	0	0	0
Sum		**0.81**	**4**	**25**	**5**	**34**

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92588

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 audiology How often? Commonly

Specialty otorhinolaryngology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 125824
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty audiology Frequency 450000 Percentage 70.09 %

Specialty otorhinolaryngology Frequency 190000 Percentage 29.59 %

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? 125,824 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 for 2009 Medicare Claims

Specialty audiology Frequency 88000 Percentage 69.93 %

Specialty otorhinolarynogology Frequency 37500 Percentage 29.80 %

Specialty Frequency Percentage %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 92588

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

	A	B	C	D	E	F	G	H	I
1				92558		92587		92588	
2	**Meeting Date: 04/2011 AMA/Specialty Society RVS Update Committee Recommendation**	**CMS**	**Staff**	**Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis**		**Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report**		**Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report (for central auditory function evaluation, see 92620, 92621)**	
3	**LOCATION**	**Code**	**Type**	**Facility**	**Facility**	**Facility**	**Facility**	**Non Facility**	**Facility**
4	**GLOBAL PERIOD**								
5	**TOTAL CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
9	**PRE-SERVICE**								
10	**Start: Following visit when decision for surgery or procedure made**								
11	Complete pre-service diagnostic & referral forms								
12	Coordinate pre-surgery services								
13	Schedule space and equipment in facility								
14	Provide pre-service education/obtain consent								
15	Follow-up phone calls & prescriptions								
16	Other Clinical Activity (please specify)								
17	**End: When patient enters office/facility for surgery/procedure**								
18	**SERVICE PERIOD**								
19	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**								
20	Greet patient, provide gowning, ensure appropriate medical records are available								
21	Obtain vital signs								
22	Provide pre-service education/obtain consent								
23	Prepare room, equipment, supplies								
24	Setup scope (non facility setting only)								
25	Prepare and position patient/ monitor patient/ set up IV								
26	Sedate/apply anesthesia								
27	**Intra-service**								
28	Assist physician in performing procedure								
29	**Post-Service**								
30	Monitor pt. following service/check tubes, monitors, drains								
31	Clean room/equipment by physician staff								
32	Clean Scope								
33	Clean Surgical Instrument Package								
34	Complete diagnostic forms, lab & X-ray requisitions								
35	Review/read X-ray, lab, and pathology reports								
36	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions								
37	Discharge day management								
38	Other Clinical Activity (please specify)								
39	**End: Patient leaves office**								
40	**POST-SERVICE Period**								
41	**Start: Patient leaves office/facility**								
42	Conduct phone calls/call in prescriptions								
51	*Total Office Visit Time*			**0**	**0**	**0**	**0**	**0**	**0**
52	Other Activity (please specify)								
53	**End: with last office visit before end of global period**				**0**		0		0
54	**MEDICAL SUPPLIES**		**Unit**						
55	ear tip, immittance	SD045		**1**		1		1	
56	specula tips, otoscope	SM025				1		1	
57	'paper, recording (per sheet)	SK059		**2**		2		2	
58	swab-pad, alcohol	SJ053		**2**		2		2	
59	**Equipment**		**Min**						
60	'audiometric soundproof booth (exam and control rooms)	EQ054		**5**		12		25	
61	'OAE-otoacoustic emission system	EQ034		**5**		12		25	
62	chair with headrest, exam, reclining	EF008		**5**		12		25	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Codes Reported Together 75% or More Screen

April 2011

Pulmonary Function Testing

In February 2010, CPT codes 94240, 94260, 94350, 94360, 94370 and 94725 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These codes are commonly billed together with 94720, 94360, 94240 and 94350. In February 2011, the specialty submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created four bundled services for RUC review in April 2011. The specialty informed the RUC that these tests are not automated.

94726 ***Plethysmography for determination of lung volumes and, when performed, airway resistance***
The RUC reviewed the survey results from 40 pulmonary physicians for CPT code 94726. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. The RUC reviewed the survey work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared the physician work of 94726 to the key reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared the surveyed code, 7 minutes compared to 5 minutes, the survey respondents rated 94726 as a more intense and complex procedure. Therefore, the work values should be identical. Also, the RUC compared 94726 to the reference code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94726.**

94727 ***Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes***
The RUC reviewed the survey results from 36 pulmonary physicians for CPT code 94727. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. The RUC reviewed the survey's estimated work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared 94727 to the key reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared to the surveyed code, 7 minutes and 5 minutes, the survey respondents rated 94727

as a more intense and complex procedure. Therefore, the work values should be identical. Also, the RUC compared 94727 to CPT code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94727.**

94728 ***Airway resistance by impulse oscillometry***
The RUC reviewed the survey results from 31 pulmonary physicians for CPT code 94728. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. In addition, the specialty explained that while 94728 and 94727 can be billed together, this is not typical as the typical scenario for 94728 involves a pediatric patient. The RUC reviewed the survey work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared 94728 to the reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared to the surveyed code, 7 minutes and 5 minutes, 94728 is a more intense procedure compared to the reference code. Therefore, the work values should be identical. Also, the RUC compared 94728 to the reference code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94728.**

94729 ***Diffusing capacity (eg, carbon monoxide, membrane)***
The RUC reviewed the survey results from 42 pulmonary physicians for CPT code 94729. The RUC recommends intra-service time of 5 minutes for this ZZZ global code. The RUC reviewed the survey's estimated work values and agreed that the survey respondents overestimated the work value of this procedure. To determine an appropriate work value for this procedure, the RUC reviewed other ZZZ global codes with similar physician work. The RUC reviewed 93352 *Use of echocardiographic contrast agent during stress echocardiography* (work RVU= 0.19) and agreed that this service has comparable physician work and intensity with identical intra-service time of 5 minutes. Therefore, the work value of 94729 should be directly crosswalked to 93352. To further justify a work RVU of 0.19, the RUC compared the surveyed code to the reference code 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour* (work RVU= 0.19) and agreed that the two services have similar physician work and intensity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.19 for CPT code 94729.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was specifically refined to reflect the typical patient service. It was also recommended and agreed there were no direct inputs in the facility setting for this service.

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 93720		~~Plethysmography, total body; with interpretation and report~~	XXX	N/A
D 93721		~~Plethysmography, total body; tracing only, without interpretation and report~~	XXX	N/A
D 93722		~~Plethysmography, total body; interpretation and report only~~ ~~(For regional plethysmography, see 93875-93931)~~ (93720-93722 have been deleted. To report, use 94726.)	XXX	N/A
E 94010		Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation (Do not report 94010 in conjunction with 94728, 94150, 94200, 94375 ~~in conjunction with 94010~~)	XXX	0.17 (No Change)
94060		Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Do not report 94060 in conjunction with 94728, 94150, 94200, 94375 ~~in conjunction with 94060~~)	XXX	0.31 (No Change)
E 94150		Vital capacity, total (separate procedure)	XXX	0.07 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 94150 in conjunction with 94728, 94010, 94060 ~~in conjunction with 94150~~ To report thoracic gas volumes, see 94726, 94727.)		
E 94200		Maximum breathing capacity, maximal voluntary ventilation (Do not report 94200 in conjunction with 94010, 94060 ~~in conjunction with 94200~~)	XXX	0.11 (No Change)
D 94240		~~Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method~~	XXX	N/A
D 94260		~~Thoracic gas volume~~ ~~(For plethysmography, see 93720-93722)~~ (94240, 94260 have been deleted. To report thoracic gas volumes, see 94726, 94727.)	XXX	N/A
D 94350		~~Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time~~ (94350 has been deleted. To report, use 94726,94727.)	XXX	N/A
D 94360		~~Determination of resistance to airflow, oscillatory or plethysmographic methods~~ (94360 has been deleted. To report, see 94726, 94728.)	XXX	N/A
D 94370		~~Determination of airway closing volume, single breath tests~~ (94370 has been deleted. To report, use 94726, 94727.)	XXX	N/A
E 94375		Respiratory Flow Volume Loop	XXX	0.31 (No Change)

CPT Code (•New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 94375 in conjunction with 94728, 94010, 94060)		
D 94720		~~Carbon monoxide diffusing capacity (eg, single breath, steady state)~~	XXX	N/A
D 94725		~~Membrane diffusion capacity~~ (94720, 94725 have been deleted. To report, see 94729.)	XXX	N/A
●94726	FF1	Plethysmography for determination of lung volumes and when performed, airway resistance (Do not report 94726 in conjunction with 94727, 94728)	XXX	0.31
●94727	FF2	Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report 94727 in conjunction with 94726)	XXX	0.31
●94728	FF3	Airway resistance by impulse oscillometry (Do not report 94728 in conjunction with 94726, 94010, 94060, 94070, 94375)	XXX	0.31
● +94729	FF4	Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report 94729 in conjunction with 94726-94728, 94010, 94060, 94070, 94375)	ZZZ	0.19

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94726 Tracking Number FF1 Original Specialty Recommended RVU: **0.31**
Presented Recommended RVU: **0.31**
Global Period: XXX RUC Recommended RVU: **0.31**

CPT Descriptor: Plethysmography for determination of lung volumes and when performed, airway resistance (Do not report 94726 in conjunction with 94727, 94728)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male complains of respiratory symptoms. Pulmonary function tests using body plethysmography are performed.

Percentage of Survey Respondents who found Vignette to be Typical: 80.00%

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:
- Review results of previous Pulmonary Function Testing
- Review order request and diagnosis to ensure that ordered tests were performed
- Review accuracy of race, gender, age, height, smoking status

Description of Intra-Service Work:
- Verify that predicted values are correct for the patient tested
- Review pressure volumes curves from plethysmography
- Review pressure/flow results from airway resistance
- Check results for errors in the 3-8 maneuvers as noted by the RN/RT.
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:
- Review transcribed report, check for errors and sign the corrected report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS				
Specialty(s):	American College of Chest Physicians and the American Thoracic Society				
CPT Code:	94726				
Sample Size:	153	**Resp N:**	40	**Response:** 26.1 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	37.50	**100.00**	200.00	1000.00
Survey RVW:	0.22	0.31	**0.40**	0.61	1.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	3.00	**5.00**	10.00	35.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	94726	**Recommended Physician Work RVU: 0.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
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:		**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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
94375	XXX	0.31	**RUC Time**

CPT Descriptor Respiratory flow volume loop

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.00	**RUC Time**	1,256,953

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94621	XXX	1.42	**RUC Time**	9,849

CPT Descriptor 2 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

Other Reference CPT Code	Global	Work RVU	Time Source
		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: 13 **% of respondents:** 32.5 **%**

TIME ESTIMATES (Median)	**CPT Code: 94726**	**Key Reference CPT Code:** 94375	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	5.00	7.00	
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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**17.00**
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	2.85	2.69
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.62	2.46
Urgency of medical decision making	2.38	2.31
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	2.85
Physical effort required	1.23	1.23
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.15	2.08
Outcome depends on the skill and judgment of physician	3.08	2.92
Estimated risk of malpractice suit with poor outcome	2.15	2.08

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.31	2.08
Intra-Service intensity/complexity	2.77	2.62
Post-Service intensity/complexity	2.62	2.54

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 Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

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

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

3.	Code	RVW	Global	Pre	Intra	Post	Total
4.	94729	0.19	ZZZ	0	5	0	5
5.	94010	0.17	XXX	0	5	2	7
6.	94060	0.31	XXX	5	10	5	20
7.	94070	0.60	XXX	0	15	0	15
8.	94375	0.31	XXX	5	7	5	17

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93720, 93721, 93722, 94240, 94260, 94360

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

Specialty Pulmonary Disease — 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? 2114655
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Extrapolated Medicare frequency by assuming that Medicare Frequency is 33.33% of the size of national frequency. Also, our assumption is using the same ratios as the Medicare data.

Specialty Pulmonary Disease — Frequency 1621956 — Percentage 76.70 %

Specialty Internal Medicine — Frequency 201075 — Percentage 9.50 %

Specialty Critical Care — Frequency 82530 — Percentage 3.90 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 314,037 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 50% of utilization for 94240. Other utilization for bundled, deleted codes will be savings.

Specialty Pulmonary Disease	Frequency 240867	Percentage 76.70 %
Specialty Internal Medicine	Frequency 67016	Percentage 21.34 %
Specialty Critical Care	Frequency 6154	Percentage 1.95 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93720

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94727 Tracking Number FF2 Original Specialty Recommended RVU: **0.31**
Presented Recommended RVU: **0.31**
Global Period: XXX RUC Recommended RVU: **0.31**

CPT Descriptor: Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report 94727 in conjunction with 94726)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male complains of respiratory symptoms. Pulmonary function tests assessed by gas dilution are performed.

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

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:
- Reviewing results of previous Pulmonary Function Testing.
- Review order request and diagnosis to ensure that ordered tests were performed
- Review accuracy of race, gender, age, height, smoking status

Description of Intra-Service Work:
- Verify that predicted values are correct for the patient tested
- Review nitrogen wash-out or helium wash-in curves
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:
- Review transcribed report, check for errors and sign the corrected report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS					
Specialty(s):	American College of Chest Physicians and the American Thoracic Society					
CPT Code:	94727					
Sample Size:	153	**Resp N:**	36	**Response:** 23.5 %		
Sample Type:	Random	**Additional Sample Information:**				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**32.50**	200.00	2000.00
Survey RVW:	0.17	0.31	**0.41**	0.61	1.20
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	4.00	**5.00**	10.00	30.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	94727	**Recommended Physician Work RVU: 0.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
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:		**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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
94375	XXX	0.31	**RUC Time**

CPT Descriptor Respiratory flow volume loop

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,256,953

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94621	XXX	1.42	**RUC Time**	9,849

CPT Descriptor 2 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

Other Reference CPT Code	Global	Work RVU	Time Source
		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: 13 **% of respondents:** 36.1 **%**

TIME ESTIMATES (Median)	**CPT Code: 94727**	**Key Reference CPT Code:** 94375	**Source of Time RUC Time**
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	5.00	7.00	
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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**17.00**
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	2.92	2.85
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.85	2.69
Urgency of medical decision making	2.23	2.38
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.15	2.92
Physical effort required	1.25	1.25
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.23	2.15
Outcome depends on the skill and judgment of physician	3.23	3.15
Estimated risk of malpractice suit with poor outcome	2.23	2.23

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.38	2.23
Intra-Service intensity/complexity	2.85	2.69
Post-Service intensity/complexity	2.69	2.54

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 Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

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

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

3.	Code	RVW	Global	Pre	Intra	Post	Total
4.	94728	0.31	XXX	5	10	5	20
5.	94729	0.30	ZZZ	0	5	0	5
6.	94010	0.17	XXX	0	5	2	7
7.	94060	0.31	XXX	5	10	5	20
8.	94070	0.60	XXX	0	15	0	15
9.	94375	0.31	XXX	5	7	5	17

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 94240, 94260, 94350, 94370

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

Specialty Pulmonary Disease 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? 1960647
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Extrapolated Medicare frequency by assuming that Medicare Frequency is 33.33% of the size of national frequency. Also, our assumption is using the same ratios as the Medicare data.

Specialty Pulmonary Disease Frequency 1356366 Percentage 69.17 %

Specialty Internal Medicine Frequency 228087 Percentage 11.63 %

Specialty Critical Care Frequency 58683 Percentage 2.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 314,037 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 50% of utilization for 94240. Other utilization for bundled, deleted codes will be savings.

Specialty Pulmonary Disease	Frequency 217220	Percentage 69.17 %
Specialty Internal Medicine	Frequency 36523	Percentage 11.63 %
Specialty Critical Care	Frequency 9422	Percentage 3.00 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 94240

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94728 Tracking Number FF3 Original Specialty Recommended RVU: **0.31**
Presented Recommended RVU: **0.31**
Global Period: XXX RUC Recommended RVU: **0.31**

CPT Descriptor: Airway resistance by impulse oscillometry (Do not report 94728 in conjunction with 94726, 94010, 94060, 94070, 94375)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A four-year-old boy presents with respiratory symptoms. Diagnostic pulmonary function tests by impulse oscillometry are performed.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

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:
- Reviewing results of previous Pulmonary Function Testing
- Review order request and diagnosis to ensure that ordered tests were performed
- Review accuracy of race, gender, age, height, smoking status

Description of Intra-Service Work:
- Verify that predicted values are correct for the patient tested
- Review resistance and reactance distribution over different phases of tidal breathing
- Checking results for errors in the 3-8 maneuvers before and after the administration of the bronchodilator as noted by the RN/RT.
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:
- Review transcribed report, check for errors and sign the corrected report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS				
Specialty(s):	American College of Chest Physicians and the American Thoracic Society				
CPT Code:	94728				
Sample Size:	153	**Resp N:**	31	**Response:** 20.2 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	28.75	1100.00
Survey RVW:	0.15	0.31	**0.50**	0.73	2.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	4.50	**10.00**	10.00	30.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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:	94728	**Recommended Physician Work RVU: 0.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments to Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
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:		**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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
94010	XXX	0.17	**RUC Time**

CPT Descriptor Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94010	XXX	0.17	**RUC Time**	1,256,953

CPT Descriptor 1 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94621	XXX	1.42	**RUC Time**	9,849

CPT Descriptor 2 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

Other Reference CPT Code	Global	Work RVU	Time Source
		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: 9 **% of respondents:** 29.0 **%**

TIME ESTIMATES (Median)	**CPT Code: 94728**	**Key Reference CPT Code:** 94010	**Source of Time** **RUC Time**
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	5.00	2.00	
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 Subsequent Observation Care Time	0.0	0.00
Median Total Time	**15.00**	**7.00**
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	3.00	2.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.89
Urgency of medical decision making	3.00	2.67
Technical Skill/Physical Effort (Mean)		
Technical skill required	3.00	2.89
Physical effort required	1.67	1.56
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	2.00	1.89
Outcome depends on the skill and judgment of physician	3.11	2.89
Estimated risk of malpractice suit with poor outcome	1.89	2.00

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.11	1.78
Intra-Service intensity/complexity	2.44	2.11
Post-Service intensity/complexity	2.22	2.11

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 Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

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

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

3.	Code	RVW	Global	Pre	Intra	Post	Total
4.	94727	0.31	XXX	5	5	5	15
5.	94729	0.30	ZZZ	0	5	0	5

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 94360

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 Pulmonary Disease 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? 485055
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Extrapolated Medicare frequency by assuming that Medicare Frequency is 33.33% of the size of national frequency. Also, our assumption is using the same ratios as the Medicare data.

Specialty Pulmonary Disease Frequency 377421 Percentage 77.80 %

Specialty Internal Medicine Frequency 44139 Percentage 9.09 %

Specialty Critical Care Frequency 21537 Percentage 4.44 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 161,685 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. Aggregated the RUC 2009 Medicare Data for all of the corresponding deleted codes.

Specialty Pulmonary Disease	Frequency 125807	Percentage 77.80 %
Specialty Internal Medicine	Frequency 14713	Percentage 9.09 %
Specialty Critical Care	Frequency 7179	Percentage 4.44 %

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

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Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 94375

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:94729 Tracking Number FF4 Original Specialty Recommended RVU: **0.30**
Presented Recommended RVU: **0.30**
Global Period: ZZZ RUC Recommended RVU: **0.19**

CPT Descriptor: Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report 94729 in conjunction with 94726-94728, 94010, 94060, 94070, 94375)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old man complains of shortness of breath. In addition to other pulmonary function tests, diffusing capacity is performed to assess for emphysema or interstitial lung disease.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

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:

Description of Intra-Service Work:

- Verify that predicted values are correct for the patient tested
- Check results for errors in the 2-3 maneuvers as noted by the RN/RT.
- Check inspired vital capacity values for comparison to vital capacity
- Check breath hold times
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS				
Specialty(s):	American College of Chest Physicians and the American Thoracic Society				
CPT Code:	94729				
Sample Size:	153	**Resp N:**	42	**Response:** 27.4 %	
Sample Type:	Random	**Additional Sample Information:**			

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	31.50	**100.00**	275.00	2000.00
Survey RVW:	0.03	0.30	**0.39**	0.50	2.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	3.00	**5.00**	10.00	30.00

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (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: ZZZ Global Code

CPT Code:	94729	**Recommended Physician Work RVU: 0.19**		
		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:		**5.00**		

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** 99217x **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**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **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:

Key CPT Code	Global	Work RVU	Time Source
94375	XXX	0.31	**RUC Time**

CPT Descriptor Respiratory flow volume loop

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

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
N/A		0.00		

CPT Descriptor 1

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
		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: 20 **% of respondents:** 47.6 **%**

TIME ESTIMATES (Median)	**CPT Code: 94729**	**Key Reference CPT Code:** 94375	**Source of Time RUC Time**
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	5.00	7.00	
Median Immediate Post-service Time	0.00	5.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	0.00	
Median Office Visit Time	0.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	**5.00**	**17.00**	

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	2.55	2.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.35	2.40
Urgency of medical decision making	2.25	2.35
Technical Skill/Physical Effort (Mean)		
Technical skill required	2.80	2.60
Physical effort required	1.55	1.55
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	1.90	1.90
Outcome depends on the skill and judgment of physician	2.80	2.80
Estimated risk of malpractice suit with poor outcome	1.90	1.90

INTENSITY/COMPLEXITY MEASURES	**CPT Code**	**Reference Service 1**
Time Segments (Mean)		
Pre-Service intensity/complexity	2.00	2.00
Intra-Service intensity/complexity	2.65	2.45
Post-Service intensity/complexity	2.42	2.42

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 Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

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

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

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

3.	Code	RVW	Global	Pre	Intra	Post	Total
4.	94726	0.31	XXX	4.5	5	5	14.5
5.	94727	0.31	XXX	5	5	5	15
6.	94728	0.31	XXX	5	10	5	20
7.	94010	0.17	XXX	0	5	2	7
8.	94060	0.31	XXX	5	10	5	20
9.	94375	0.31	XXX	5	7	5	17

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 94720, 94725

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

Specialty Pulmonary Disease 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? 2801568
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Extrapolated Medicare frequency by assuming that Medicare Frequency is 33.33% of the size of national frequency. Also, our assumption is using the same ratios as the Medicare data.

Specialty Pulmonary Disease Frequency 2188227 Percentage 78.10 %

Specialty Internal Medicine Frequency 266307 Percentage 9.50 %

Specialty Critical Care Frequency 107214 Percentage 3.82 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 897,945 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Utilization of 94720. All other bundled, delted codes is savings.

Specialty Pulmonary Disease	Frequency 701296	Percentage 78.10 %
Specialty Internal Medicine	Frequency 88717	Percentage 9.88 %
Specialty Critical Care	Frequency 34302	Percentage 3.82 %

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

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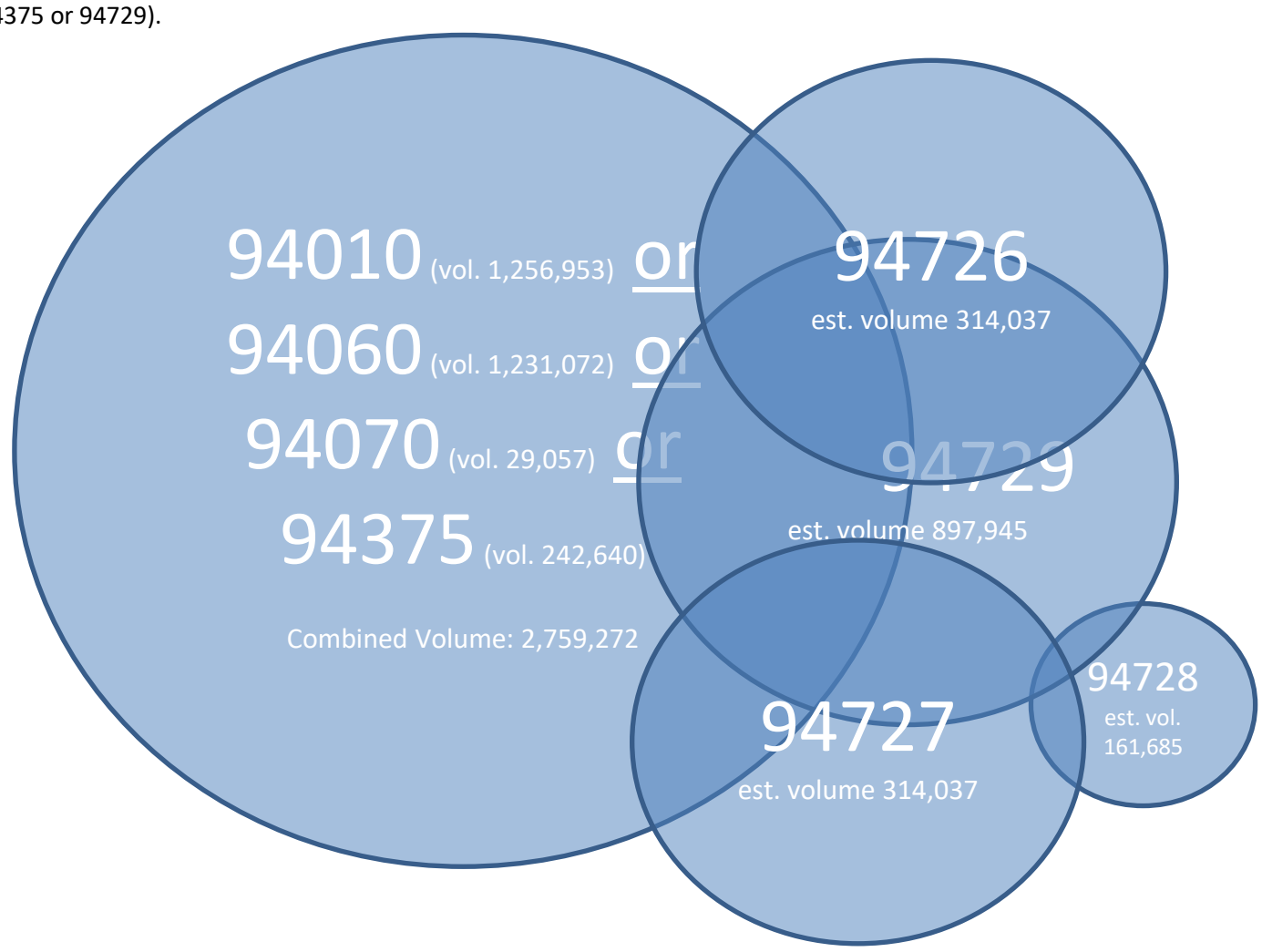
Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 94720

Revised Family of Pulmonary Function Testing Codes

Instructions: Only codes in the below diagram that are overlapping can be reported with each other. If circles are not directly touching, then those codes cannot be reported with each other (ie 94726 and 94728 cannot be reported together because they are not overlapping; 94726 can be billed with either 94010 or 94060 or 94070 or 94375 or 94729).



Bundled Codes Crosswalk

93720 93721 93722 94240 94260 94360	94726
94240 94350 94370	94727
94360	94728
94720 94725	94729

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

Global Period: **XXX** for **94726-94728** and **ZZZ** for **94729**

CPT Long Descriptors:
94726: Plethysmography for determination of lung volumes and when performed, airway resistance (Do not report 94726 in conjunction with 94727, 94728)

94727: Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report 94727 in conjunction with 94726)

94728: Airway resistance by impulse oscillometry (Do not report 94728 in conjunction with 94726, 94010, 94060, 94070, 94375)

+94729: Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report 94729 in conjunction with 94726-94728, 94010, 94060, 94070, 94375)

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee:
The ACCP and ATS convened a consensus panel to develop recommendations for these codes. The composition of this panel included private practice and academic pulmonologists in varying types of practices and locations.

If you have provide any comparison practice expense inputs on your spreadsheet, please provide a rationale for the selection of codes. Comparison Code Rationale:
94726-94729 are 4 codes that are bundling 10 deleted codes. Below is a table showing the 10 codes that are being deleted and which of the 4 bundled codes they correspond with. The grouping was done by methodology.

Old Code	New Code	Descriptor
93720	94726	Plethysmography, total body; with interpretation and report
93721	94726- TC	Plethysmography, total body; tracing only, without interpretation and report
93722	94726- 26	Plethysmography, total body; interpretation and report only
94240	94726 94727	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method
94260	94726 94727	Thoracic gas volume
94350	94727	Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time
94370	94727	Determination of airway closing volume, single breath tests
94360	94726 94728	Determination of resistance to airflow, oscillatory or plethysmographic methods
94720	94729	Carbon monoxide diffusing capacity (eg, single breath, steady state)

94725	94729	Membrane diffusion capacity

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- None

Intra-Service Clinical Labor Activities:

- Greets patient, determines time of last meal, alcohol ingestion or tobacco use, ask about eardrum perforation to assess whether plugging of ears will be necessary, determine potential infectious risk
- Prepares room, determines barometric pressure, readies equipment including calibration and supplies
- Provides explanation of the test to the patient/family, instruction and/or counseling
- Obtain height (sometimes via arm span), weight, blood pressure, SpO2 and pulse rate.
- Perform procedure via Plethysmography/ Gas dilution/ Oscillometry
- Coach patient through the procedure, adjusting nose clips as needed
- Cleans room and equipment
- Prints and documents all tests and evaluates the best effort

Post-Service Clinical Labor Activities:

- Review interpretation and coordinate with other providers

94726: Explanation of PE

Greet patient, ensure appropriate medical records are available: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for greeting the patient. However, since the procedure is typically performed on the same day as an E/M, this time is incorporated into the E/M visit. Therefore no time is allotted.

Obtain Vital Signs: Our consensus panel determined that vital signs are taken, including 6 vital signs, which would be assigned 5 minutes. However, since 3 vital signs (3 minutes) are contained within the E/M visit, only the difference of 2 minutes is included in the total clinical labor time for these studies.

Provide Pre-Service Education/ Obtain Consent: Our experts determined that this task takes approximately 4 minutes for Plethysmography.

Preparing Room, Equipment and Supplies: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing the room, equipment and supplies.

Prepare and Position Patient: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing and positioning the patient.

Performing the Procedure: Our experts determined that we could crosswalk the time of this task to the currently accepted time for 93720, Plethysmography, 25 minutes.

Monitoring the Patient Following the Service: Our consensus panel determined that 3 minutes is appropriate.

Clean Room/ Equipment by Physician Staff: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for cleaning the room and equipment by the physician staff.

Complete diagnostic forms, lab and X-ray requisitions: 3 minutes are allotted to select the appropriate data to include in the report and print the report.

Home Care Instructions/ Coordinate Office Visits/ Prescriptions: Our consensus panel determined that 3 minutes is appropriate. This may include walking the patient/family back to another location for ongoing care.

Other Clinical Activities; Review Interpretation and Coordinate with Other Providers: Our consensus panel has determined that this task should be 3 minutes.

94726: Explanation of Medical Supplies

The medical supplies used for 94726 are crosswalked from 93720, Plethysmography, with the following exceptions:

Glutaraldehyde and glutaraldehyde test strips are no longer deemed typical. A thermometer cover is no longer typical. 4 sheets of paper are used to print out the results. One ounce of disinfectant is used for cleaning.

Also, the oxygen usage would be 50 liters. This is calculated by the total clinical labor time minus the time in the body plethysmograph (50 minutes minus 25 minutes=25 min) multiplied by 2 liter per minute flow.

94726: Explanation of Equipment

The only equipment used for this Plethysmography is a Vmax 229 (PFT equip, computer system) and is used for 50 minutes.

94727: Explanation of PE

Greet patient, ensure appropriate medical records are available: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for greeting the patient. However, since the procedure is typically performed on the same day as an E/M, this time is incorporated into the E/M visit. Therefore no time is allotted.

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Obtain Vital Signs: Our consensus panel determined that vital signs are taken, including 6 vital signs, which would be assigned 5 minutes. However, since 3 vital signs (3 minutes) are contained within the E/M visit, only the difference of 2 minutes is included in the total clinical labor time for these studies.

Provide Pre-Service Education/ Obtain Consent: Our experts determined that this task takes approximately 4 minutes for Gas Dilution. This is supported by the amount currently used for 94240, Residual Lung Capacity.

Preparing Room, Equipment and Supplies: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing the room, equipment and supplies.

Prepare and Position Patient: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing and positioning the patient.

Performing the Procedure: Our experts determined that we could crosswalk the time of this task to the currently accepted time for 94240, Residual Lung Capacity, 10 minutes.

Monitoring the Patient Following the Service: Our consensus panel determined that 3 minutes is appropriate.

Clean Room/ Equipment by Physician Staff: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for cleaning the room and equipment by the physician staff.

Complete diagnostic forms, lab and X-ray requisitions: 3 minutes are allotted to select the appropriate data to include in the report and print the report.

Home Care Instructions/ Coordinate Office Visits/ Prescriptions: Our consensus panel determined that 3 minutes is appropriate. This may include walking the patient/family back to another location for ongoing care.

Other Clinical Activities; Review Interpretation and Coordinate with Other Providers: Our consensus panel has determined that this task should be 3 minutes.

94727: Explanation of Medical Supplies

For Gas Dilution, a pulmonary function filter, a mouthpiece, a noseclip and nonsterile gloves are 50 liters of oxygen are typically used, which is the same amount we are using for 94726. This is calculated by the total clinical labor time minus the time in the body plethysmograph (35 minutes minus 10 minutes=25 min) multiplied by 2 liter per minute flow used. 4 sheets of paper are used to print out the results. One ounce of disinfectant is used for cleaning.

Glutaraldehyde and glutaraldehyde test strips are no longer deemed typical.

94727: Explanation of Equipment

Our experts have determined that the use of a Vmax 229 (PFT equip, computer system) and a pulse oximeter w-printer are typical and both are used for 35 minutes.

94728: Explanation of PE

Greet patient, ensure appropriate medical records are available: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for greeting the patient. However, since the procedure is typically performed on the same day as an E/M, this time is incorporated into the E/M visit. Therefore no time is allotted.

Obtain Vital Signs: Our consensus panel determined that vital signs are taken, including 6 vital signs, which would be assigned 5 minutes. However, since 3 vital signs (3 minutes) are contained within the E/M visit, only the difference of 2 minutes is included in the total clinical labor time for these studies.

Provide Pre-Service Education/ Obtain Consent: Our experts determined that this task takes approximately 5 minutes for airway resistance by impulse oscillometry. This is chiefly to explain to parents the procedures involved.

Preparing Room, Equipment and Supplies: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing the room, equipment and supplies.

Prepare and Position Patient: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing and positioning the patient.

Performing the Procedure: Our experts determined that we could crosswalk the time of this task to the currently accepted time for 94375, Respiratory Flow Volume Loop, 14 minutes. This involves performing pre- and post-bronchodilator tests. The wait time after administration of bronchodilator is not included, as it assumes the technician will be working on other activities during the wait period.

Monitoring the Patient Following the Service: No monitoring of the patient after testing is needed.

Clean Room/ Equipment by Physician Staff: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for cleaning the room and equipment by the physician staff.

Complete diagnostic forms, lab and X-ray requisitions: 3 minutes are allotted to select the appropriate data to include in the report and print the report.

Other Clinical Activities; Review Interpretation and Coordinate with Other Providers: Our consensus panel has determined that this task should be 3 minutes.

94728: Explanation of Medical Supplies

For Airway resistance by impulse oscillometry, a nebulizer mouthpiece with tubing, a pulmonary function filter, a mouthpiece, a noseclip and nonsterile gloves are used. 4 sheets of paper are used to print out the results. One ounce of disinfectant is used for cleaning.

Glutaraldehyde and glutaraldehyde test strips are no longer deemed typical.

94728: Explanation of Equipment

For Airway resistance by impulse oscillometry, our experts have determined that an oscillometry machine (invoice included with submission) is typical and is used for 34 minutes.

94729: Explanation of PE

Greet patient, ensure appropriate medical records are available: As this is a ZZZ add-on code, no time is allotted for this.

Obtain Vital Signs: As this is a ZZZ add-on code, no time is allotted for this.

Provide Pre-Service Education/ Obtain Consent: Our experts agreed that this task takes approximately 1 minute for Diffusing Capacity. This is chiefly to explain the use of carbon monoxide for inhalation.

Preparing Room, Equipment and Supplies: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing the room, equipment and supplies.

Prepare and Position Patient: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing and positioning the patient.

Performing the Procedure: Our experts determined that we could crosswalk the time of this task to the currently accepted time for 94720, Monoxide Diffusing Capacity, 20 minutes.

Monitoring the Patient Following the Service: Our consensus panel determined that 3 minutes is appropriate.

Clean Room/ Equipment by Physician Staff: Due to the fact that 94729 will be a ZZZ code (add-on code), we have decided not to include any value for cleaning the room, as this would already be included in the other code being billed with 94729.

Hemoglobin adjustment: One minute is allowed for the technician to look up the most recent hemoglobin level and adjust the calculations to reflect this value.

Complete diagnostic forms, lab and X-ray requisitions: 1 minute is allotted to select the appropriate data to include in the report and print the report.

Home Care Instructions/ Coordinate Office Visits/ Prescriptions: As this is a ZZZ add-on code, no time is allotted for this.

Other Clinical Activities; Review Interpretation and Coordinate with Other Providers: Due to the fact that 94729 will be a ZZZ code (add-on code), we have decided not to include any value for other clinical activities, as this would already be included in the other code being billed with 94729.

94729: Explanation of Medical Supplies

For Diffusing Capacity, a pulmonary function filter, a mouthpiece, a noseclip and nonsterile gloves are used. 4 sheets of paper are used to print out the results. One ounce of disinfectant is used for cleaning.

For inhalant our experts have determined that about 5 liters of the DLCO gas mix are used for three different measurements, which is 15 liters of the four gas mix (N2, O2, He, CO). This will measure out to around 25 grams.

Glutaraldehyde and glutaraldehyde test strips are no longer deemed typical.

94729: Explanation of Equipment

For Diffusing Capacity, our experts have determined that only a Vmax 62j (body plethysmograph autobox) is typical and used for 30 minutes.

	A	B	C	D	E	F	G	H	I	J	K
1	**AMA Specialty Society RVS Update Committee Recommendation**			**94726**		**94727**		**94728**		**94729**	
2	**Meeting Date: April 2011**	**CMS**	**Staff**	**Plethysmography for determination of lung**		**Gas dilution or washout for determination of lung**		**Airway resistance by impulse oscillometry**		**Diffusing Capacity (eg, carbon monoxide,**	
3	**LOCATION**	**Code**	**Type**	**Non Facility (existing)**	**Non Facility (Proposed 2012)**	**Non Facility (existing)**	**Non Facility (Proposed 2012)**	**Non Facility (existing)**	**Non Facility (Proposed 2012)**	**Non Facility (existing)**	**Non Facility (Proposed 2012)**
4	**GLOBAL PERIOD**			**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**ZZZ**
5	**TOTAL CLINICAL LABOR TIME**	**L047C**	**RN/RT**	**60.0**	**50.0**	**31.0**	**35.0**	**45.0**	**34.0**	**39.0**	**30.0**
6	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L047C**	**RN/RT**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
7	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L047C**	**RN/RT**	**50.0**	**47.0**	**31.0**	**32.0**	**45.0**	**31.0**	**39.0**	**30.0**
8	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L047C**	**RN/RT**	**5.0**	**3.0**	**0.0**	**3.0**	**0.0**	**3.0**	**0.0**	**0.0**
9	**PRE-SERVICE**										
10	**Start: Following visit when decision for surgery or procedure made**										
11	Other Clinical Activity (please specify) Review Hx and medication use (O2, nebulizer, metered dose inhaler usage, especially the timing of the last usage; and also cardiac and hypertensive meds)	**L047C**	**RN/RT**	**5**	**0**		**0**		**0**		**0**
12	**End: When patient enters office/facility for surgery/procedure**										
13	**SERVICE PERIOD**										
14	**Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure**										
15	Review Charts	**L047C**	**RN/RT**		**0**	**1**	**0**	**1**	**0**	**1**	**0**
16	Greet patient, ensure appropriate medical records are available	**L047C**	**RN/RT**	**2**	**0**	**1**	**0**	**3**	**0**	**1**	**0**
17	Obtain vital signs	**L047C**	**RN/RT**	**3**	**2**	**3**	**2**	**3**	**2**	**2**	**0**
18	Provide pre-service education/obtain consent	**L047C**	**RN/RT**		**4**	**5**	**4**	**8**	**5**	**3**	**1**
19	Prepare room, equipment, supplies	**L047C**	**RN/RT**	**2**	**2**	**2**	**2**	**5**	**2**	**4**	**2**
20	Prepare and position patient/ monitor patient/ set up IV	**L047C**	**RN/RT**	**5**	**2**		**2**	**3**	**2**	**2**	**2**
21	**Intra-service**										
22	Performing procedure	**L047C**	**RN/RT**	**25**	**25**	**10**	**10**	**14**	**14**	**20**	**20**
23	**Post-Service**										
24	Monitor pt. following service/check tubes, monitors, drains	**L047C**	**RN/RT**		**3**	**3**	**3**	**4**	**0**		**3**
25	Clean room/equipment by physician staff	**L047C**	**RN/RT**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**0**
26	Education/Instruction/Counseling	**L047C**	**RN/RT**	**10**							
27	Complete diagnostic forms, lab & X-ray requisitions	**L047C**	**RN/RT**		**3**		**3**	**1**	**3**		**1**
28	Hemoglobin adjustment	**L047C**	**RN/RT**								**1**
29	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L047C**	**RN/RT**		**3**	**3**	**3**			**3**	**0**
30	**End: Patient leaves office**										
31	**POST-SERVICE Period**										
32	**Start: Patient leaves office/facility**										
33	Conduct phone calls/call in prescriptions			**5**	**0**						
34	Other Activity (please specify) Review interpretation and coordinate with other providers	**L047C**	**RN/RT**		**3**		**3**		**3**		
35	**End: with last office visit before end of global period**										
36	**MEDICAL SUPPLIES**		**Unit**								
37	filter, pulmonary function filter	SD075	item	**1**	**1**		**1**	**1**	**1**		**1**
38	mouthpiece, respiratory	SD099	item	**1**	**1**		**1**		**1**	**1**	**1**
39	nebulizer mouthpiece with tubing	SD101	item					**1**	**1**		
40	noseclips	SD102	item	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**
41	gloves, non-sterile	SB022	pair	**1**	**1**	**1**	**1**		**1**		**1**
42	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	**2**	**0**		**0**		**0**		**0**
43	glutaraldehyde test strips (Cidex, Metrex)	SM019	item	**1**	**0**						
44	cover, thermometer probe	SB004	item	**1**	**0**	**1**	**0**	**1**	**0**	**1**	**0**
45	inhalant	SH042	gm	**0.25**	**0**		**0.25**				**25**
46	gas, oxygen	SD084	liter	**66**	**50**		**50**			**150**	
47	paper, laser printing (each sheet)	SK057	item		**4**		**4**	**4**	**4**	**4**	**4**
48	disinfectant, surface (Envirocide, Sanizide)	SM013	oz		**1**	**1**	**1**	**1**	**1**	**1**	**1**
49	swab-pad, alcohol	SJ053	item			**4**					
50	**Equipment**										
51	Vmax 62j (body plethysmograph autobox)	EQ044	minutes			**1**				**1**	**30**
52	pulse oximeter w-printer	EQ211	minutes			**1**	**35**				
53	Vmax 229 (PFT equip, computer system)	EQ039	minutes	**1**	**50**		**35**	**1**	**0**		
54	computer, desktop, w-monitor	ED021		**1**				**1**			
55	Oscillometry (see included invoice)		minutes						**34**		